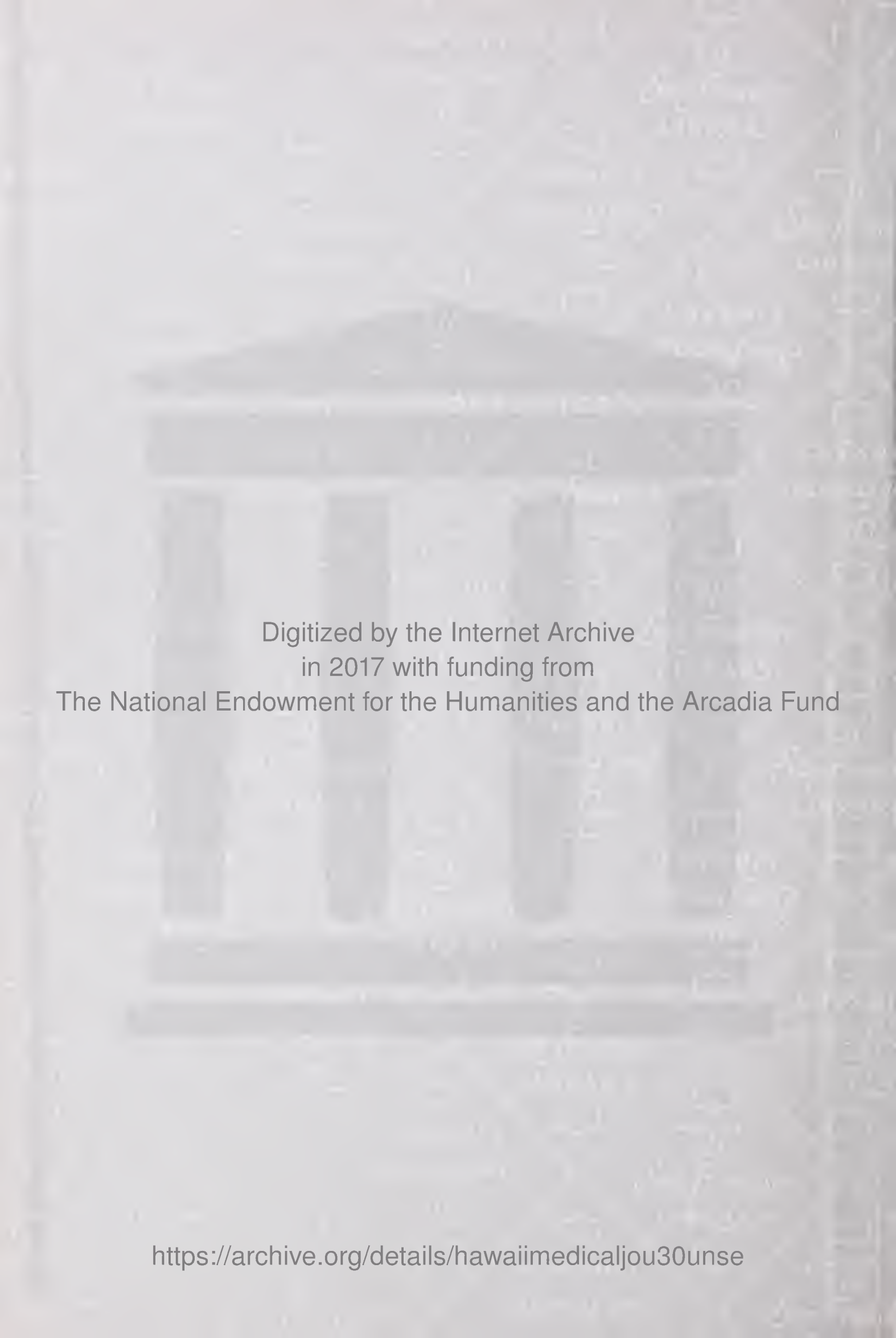

Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/hawaiimedicaljou30unse

INDEX TO VOLUME 30

Subject and Title Index

HAWAII MEDICAL JOURNAL

A

Aberrant liver tissue presenting as accessory spleen on spleen scan following splenectomy..... 393
Activated coagulation time test as a control for heparin therapy 474
Addict detoxification in a community hospital..... 478
Alcohol and drug abuse in Hawaii..... 383
Anaphylactoid purpura associated with smallpox vaccination 388
Art and gentle science of pisse-prophecy..... 166

B

Book reviews 45, 109, 199, 285, 411, 491

C

Carcinoma, radical mastectomy for, of the breast.... 258
Changing concepts of death..... 251
Clinical course for survival in the Arctic..... 31
Conquest of scurvy and the discovery of Hawaii, an ethnobotanical triumph..... 266
County Society News.....49, 113, 205, 334, 418, 494

D

Death, changing concepts of..... 251
Drug, and alcohol abuse in Hawaii..... 383

E

Editorials:
- Effecting "Death with dignity"..... 278
- Harry L. Arnold, Sr., M.D..... 404
- Health care delivery in Hawaii..... 37
- Health care delivery in Hawaii..... 101
- In Memorium—Doctors of Hawaii..... 192
- Mabel L. Smyth Memorial Building..... 102
- Makana Foundation for organ transplants, the..... 101
- MECO—Medical Education Community Orientation 103
- National health insurance—inevitable..... 37
- Nutritional emergency 38
- Romance never dies..... 103
- Sickness care vs health care..... 279
- Straub Clinic 484

Edward D. Churchill lecture..... 15
Endocarditis, infectious 396

G

Gastroesophageal reflux, hiatus hernia and..... 163
Group A beta hemolytic streptococcal bacteremia.... 270

H

Hawaii
- Academy of General Practice 40, 106, 194, 280, 409, 489
- Medical Association.....53, 116, 207, 288, 293*, 419
 * Annual House of Delegates Proceedings.
- Pharmacists' Bulletin 50, 118, 208, 336, 420, 498

Hawaii life tables values by causes of death, 1959-61 184
Heparin therapy, activated coagulation time test as a control for..... 474
Hiatus hernia and gastroesophageal reflux..... 163
HMO, performance specifications of an..... 472

I

Infectious endocarditis 396
In Memorium—
- Doctors of Hawaii.....44, 112, 198, 283, 412
- Burt, Franklin 44
- Chamberlin, Howard W..... 283
- Chinn, Walter Seong..... 412
- Craig, Alfred Leslie..... 283
- Edwards, Franz Gill..... 198
- Madsen, Mars Laurice..... 198
- McCalla, Randolph Lucien..... 413
- McCoy, Haliburton 412
- Nesbit, William Wesley..... 198
- Tisdale, Charles Lewis..... 112
- Tisdale, Thomas Price..... 112
- Watt, Henry Chorley..... 44
- Whitten, Harry Hood..... 198
- Yamamoto, Chito 283

Inside HMA 41, 105, 193, 281, 408, 488
Isolation of virulent paracolobactrum aerogenoides microorganisms from a rat..... 386

L

L-Dopa and parkinsonism..... 390
Letters 10, 85, 160, 381, 462
Life's window—the pupil..... 402
Lupus erythematosus, rheumatoid factor and antinuclear antibody in systemic, rheumatoid arthritis and infectious mononucleosis..... 170

M

Malaria—a problem for Hawaii..... 27
Malignant leiomyoblastoma report of ninth case..... 89
Marijuana, a toxicologic view of..... 262
Mastectomy, radical, for carcinoma of the breast..... 258
Mongoose, plague antibody response in the..... 92
Mononucleosis, rheumatoid factor and antinuclear antibody in systemic lupus erythematosus, rheumatoid arthritis and infectious..... 170
Multiple sclerosis: autoimmune disease..... 464

N

New Members 48, 114, 202, 291, 416, 496
Notes and News.....46, 110, 200, 286, 414, 492

O

Obituaries:
- Kurashige, Wilfred Hitoshi..... 212
- Sia, Richard Ho Ping..... 59
- Stephenson, John Robert..... 123
- Wong, Francis F. C..... 501

Our New President..... 292

270330

P

Pacific southwest regional medical library service.... 274
Paracolobactrum aerogenoides microorganisms from a rat, isolation of virulent..... 386
Performance specifications of an HMO..... 472
Plague antibody response in the mongoose..... 92
President's Page 36, 100, 191, 276, 406, 486

R

Radical mastectomy for carcinoma of the breast..... 258
Rheumatoid factor and antinuclear antibody in systemic lupus erythematosus, rheumatoid arthritis and infectious mononucleosis..... 170

S

Schizophrenia, thiothixene in chronic: a clinical trial..... 178
Scorpions and centipedes in the Hawaiian Islands: their medical significance..... 95
Scurvy, conquest of, and the discovery of Hawaii: an ethnobotanical triumph..... 266
Slants and Angles.....39, 104, 195, 282, 407, 487
Smallpox vaccination, anaphylactoid purpura associated with 388

T

Three months' experience with thiothixene..... 174
Thiothixene in chronic schizophrenia: a clinical trial..... 178
Toxicologic view of marijuana..... 262

U

University of Hawaii.....42, 196

X

X-ray View Box.....43, 108, 197, 284, 410, 490

Author Index

Balfour, J. F..... 258
Ball, James J.....266, 393
Barrett, O'Neill, Jr..... 27
Baselt, Randall C..... 262
Bonilla-Linero, Frank 474
Burgess, C. M..... 258
Casarett, Louis J..... 262
Chandor, Sebbins B..... 89
Chinen, Allan 464
Ching, George Q. L..... 386
Cho, Patricia 474
Chun, H. H..... 472
DeTata, Juan Carlos..... 174
Gardner, Kenneth D., Jr..... 166
Gilman, Nelson J..... 274
Halloran, Mary C..... 478
Hergenhan, John J..... 478
Higa, Harry H.....92, 386
Ichida, Carl K..... 170
Jim, Robert T. S..... 393
Kanzaki, Tamotsu 393
Kreitzer, Stephen M..... 270
Lowrey, John J..... 251
Lum, Carl H..... 393
McNamara, J. Judson..... 163
Martin, Carroll M..... 95
Matsumoto, Y. Scott..... 184
Matsuura, William T..... 92
Mertz, Audrey 383
Moser, Robert H..... 396
Okihiro, Michael M..... 390
Osteraas, Grayson R..... 89
Park, Chai Bin..... 184
Quisenberry, Walter B..... 383
Reiley, Carlton G..... 27
Reppun, J. I. Frederick..... 402
Rogers, Terence A..... 31
Starbuck, George W..... 478
Strode, Joseph E..... 15
Watanabe, Walter H..... 92
Wong, K. Y..... 388
Wong, Warren L. H..... 393
Yilmaz, A. Hamdi..... 178
Yim, Evelyn 474
Yokoyama, Mitsuo 170, 464

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
MAR 24 1971

JANUARY / FEBRUARY 1971

HAWAII MEDICAL JOURNAL

VOLUME 30 / NUMBER 1

William Harvey, M.D., 1578-1657, Discoverer of the Circulation of the Blood



Dr. Harvey's masterpiece, De Motu Cordis, published in 1628, was dedicated to King Charles I. It is considered the most important single book in the history of physiology.

Menrium® treats the menopausal symptoms that bother him most.



ROCHE
Roche
LABORATORIES
...ion of Hoffmann La Roche Inc
... New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through her menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

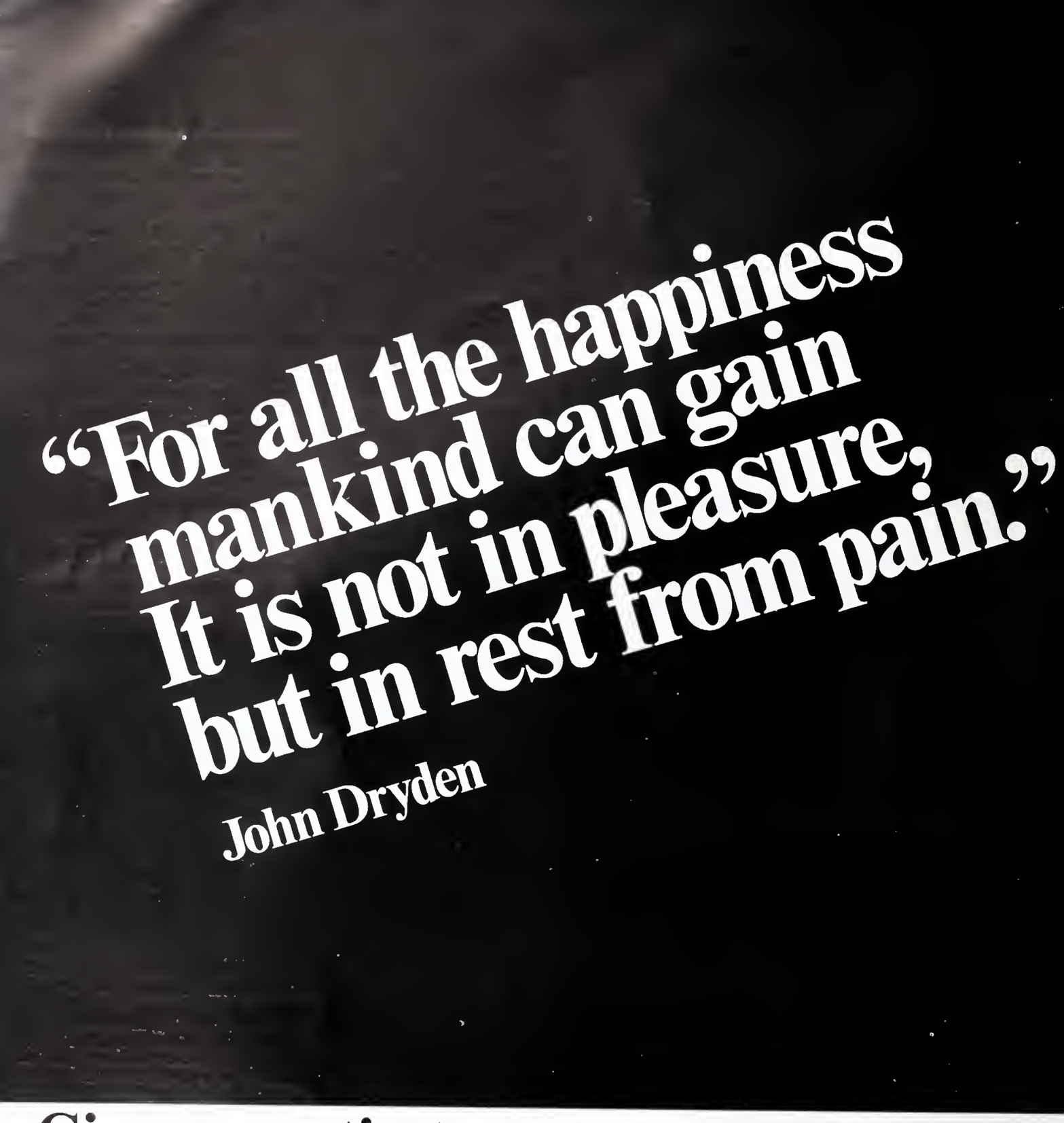
Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens



Give your patients rest from pain

Empirin® Compound with Codeine Phosphate gr. 1/2, No. 3

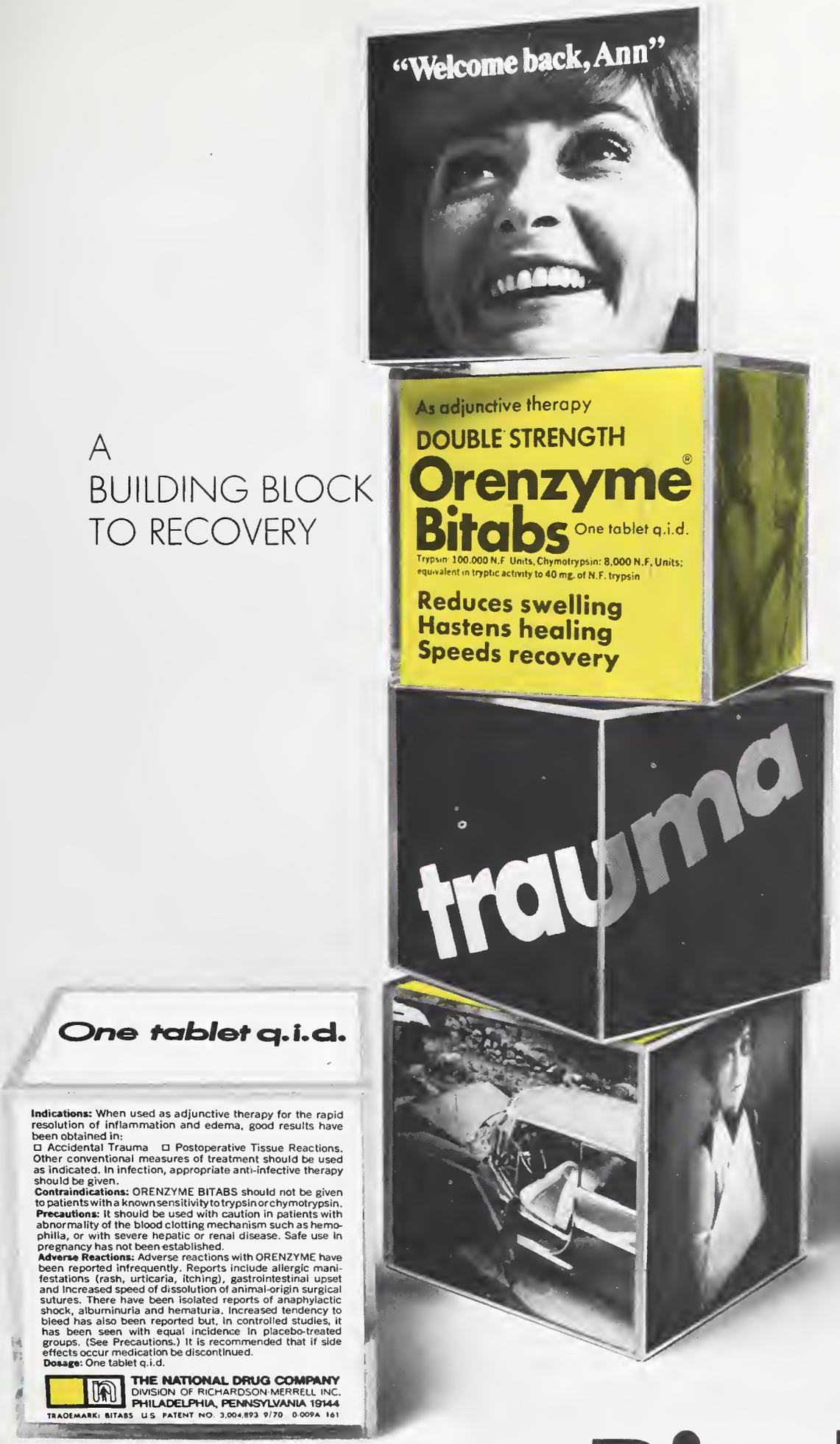
Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

B. W. & Co. narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

A
BUILDING BLOCK
TO RECOVERY



Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple



Trichomonads... monilia... bacteria
You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC
Cream (aminacrine hydrachloride 0.2%, sulfanilamide 15.0%, allantain 2.0%)

Suppositories (aminacrine hydrachlaride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.14 Gm.)

Contraindications: Knawn sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautians for topicol and systemic sulfanamides shauld be observed because of the possibility of absorption. Burning, increased lacal discomfort, skin rash, urticaria ar ather manifestotions of sulfanamide toxicity are reasans ta discantinue treatment.
Dosage: One applicatorful ar ane suppasitory intravaginally ance ar twice doily.
Supplied: Cream – Faur-aunce tube with or without applicatar. Suppositories – Box af 12 with applicatar.

TRADEMARK: AVC AV-104 2/71 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular

HAWAII MEDICAL JOURNAL

VOLUME 30, NUMBER 1

JANUARY-FEBRUARY 1971

$6.00 A YEAR • $1.00 A COPY

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1971, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter. October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

Published Bi-Monthly by the

HAWAII MEDICAL ASSOCIATION

(Incorporated in 1856 under the Monarchy)

510 S. Beretania St., Honolulu, Hawaii 96813

Editor, HARRY L. ARNOLD, JR., M.D.

News Editor, HENRY N. YOKOYAMA, M.D.

Assistant Editor, MARILYN O. WALL

Associate Editor, MERYL H. HABER, M.D.

Contributing Editor, ROBERT H. MOSER, M.D.

Book Review Editor, WINFRED Y. LEE, M.D.

The Hawaii Medical Association

Officers 1971

President • JOHN J. LOWREY, *Honolulu*

President-Elect • HERBERT Y. H. CHINN, *Honolulu*

Past President • GEORGE H. MILLS, *Honolulu*

Secretary • R. VARIAN SLOAN, *Honolulu*

Treasurer • THOMAS P. FRISSELL, *Honolulu*

County Presidents

Hawaii County • GEORGE BRACHER, *Hilo*

Honolulu County • RICHARD S. OMURA, *Honolulu*

Kauai County • GONZALO GEROSO, *Lihue*

Maui County • SAKAE UEHARA, *Wailuku*

Delegate to AMA • GEORGE H. MILLS, *Honolulu*

Alt. Delegate to AMA • THEODORE T. TOMITA, *Honolulu*

Councillors 1971

Maui • WILLIAM E. IACONETTI

Honolulu • GROVER H. BATTEN

Honolulu • WILLIAM W. L. DANG

Honolulu • RICHARD D. MOORE

Hawaii • ED B. HELMS

Kauai • YONEMICHI MIYASHIRO

Officers—County Societies—1971

HAWAII		HONOLULU
VERNE ADAMS •	President	• THOMAS FRISSELL
DEWITT H. SMITH •	Vice President	• WINFRED LEE
EDWARD BALLERINI •	Secretary	• WILLIAM DANG
ALLAN TAKASE •	Treasurer	• ELMER JOHNSON
MAUI		**KAUAI**
J. MARK B. SOWERS •	President	• CHARLES CUSTER
DENIS FU •	Vice President	• KATOK CHUANG
JOHN WITHERS •	{Secretary} {Treasurer}	• ROBERT BERRY

IT'S THEIR FUTURE...

But it's up to you to plan it. Your children gaze into the mystery of the future. But their lives in twenty or thirty years depend substantially on your vision today. They depend on your abilities with investments, taxes, estates, and trusts. And that's our field. We'd like to help . . .



BISHOP TRUST CO., LTD.

Bishop and King • Phone 536-3771
Honolulu, Hawaii 96813

HAWAII MEDICAL JOURNAL

Contents

Volume 30, No. 1 • January-February, 1971

Articles

The Edward D. Churchill Lecture 15
Joseph E. Strode, M.D.

Malaria—A Problem for Hawaii? 27
O'Neill Barrett, Jr., Colonel, MC, USA, and
Carlton G. Reiley, Lt. Colonel, MC, USA

The Clinical Course of Survival in the Arctic 31
Terence A. Rogers, Ph.D.

Editorials

Heath Care Delivery In Hawaii 37

National Health Insurance—Inevitable? 37

Nutritional Emergency 38

Features

Book Reviews 45

County Society Reports 49

Hawaii Academy of General Practice 40

Hawaii Medical Association 53

In Memoriam—Doctors of Hawaii—LXXXVIII 44

Inside HMA 41

Letters 10

New Members 48

Notes and News 46

President's Page 36

Slants and Angles 39

University of Hawaii 42

X-ray View Box 43

Hawaii Pharmacists' Bulletin

The President's Corner 50

Board of Directors Meeting 50

Rx Notes of Interest 51

Cover: From the collection of Meryl H. Haber, M.D.

"The specializer."

Thiosulfil® Forte
(sulfamethizole 0.5 Gm.)

It hits uropathogens where they live... hard and fast!

Thiosulfil Forte, a highly specialized sulfonamide, delivers its potent and rapid antibacterial action *locally*. In the urinary tract. This is where the activity is needed when you're treating cystitis or prostatitis. Thiosulfil Forte is a *true specific*—hits susceptible uropathogens where they live...hard and fast.

Rapidly absorbed and rapidly excreted, there is so little concentration in the respiratory tract and other tissues that the *only* indication for Thiosulfil Forte is in urinary tract infections. Most of the drug (more than 75 per cent in 8 hours) reaches the urinary tract in a free and active form...to fight the infection.

BRIEF SUMMARY—Bacteriostatic agent for use in Urinary Tract Infection (due to susceptible organisms)—INDICATIONS: Thiosulfil is indicated in the treatment of urinary tract infections—cystitis, urethritis, prostatitis, pyelonephritis, and pyelitis—caused by susceptible bacteria, normally **Escherichia coli, Klebsiella aerobacter, Staphylococcus aureus, Proteus mirabilis,** and less frequently, **Proteus vulgaris.** Thiosulfil is useful in the management of patients prone to urinary tract infection because of conditions such as pregnancy, diabetes, or pathology not correctable by surgery. As with most antibiotics and all antimicrobials, Thiosulfil is most effective in acute, uncomplicated urinary tract infections. **CONTRAINDICATION:** Thiosulfil is contraindicated in patients hypersensitive to sulfonamides. **WARNINGS:** Sulfonamides should not be used to treat group A streptococci infections or their sequelae. The occurrence of sore throat, fever, pallor, purpura, or jaundice during sulfonamide administration may be an early indication of serious blood dyscrasias. Frequent blood counts and renal function tests should be carried out during sulfonamide treatment, especially during prolonged administration. Microscopic urinalyses should be done once a week when a patient is treated for longer than two weeks. Urine cultures should be made to confirm eradication of bacteriuria. Clinical symptoms in acute, uncomplicated urinary tract infections frequently disappear spontaneously after three days, and their disappearance cannot be taken as evidence of absence of bacteriuria. (Para-aminobenzoic acid must be added to the culture media while the patient is on sulfonamide.) Because sulfonamides are bacteriostatic, development of resistance by the involved organisms is frequent. **PRECAUTIONS:** Sulfonamides should be administered with caution to patients with severe allergy ~~or~~ bronchial asthma. Sulfonamides should be given with caution to patients with severe impairment of hepatic or renal function. They should be administered with caution to glucose-6-phosphate dehydrogenase-deficient patients since sulfonamides may cause hemol-

Thiosulfil® Forte—
It works
where you want it...



That's also why you don't need excessive loading or priming doses. And the patient on Thiosulfil Forte uses less sulfonamide...gets more action for his money.

Specific For Urinary Tract Infections

Thiosulfil® Forte

Brand of

sulfamethizole 0.5 Gm.

ysis in such patients. Adequate fluid intake must be maintained in order to prevent crystalluria. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides), and oral hypoglycemic agents. Cross-sensitivity may exist with such agents. **ADVERSE REACTIONS:** Like all sulfonamides, Thiosulfil (sulfamethizole) could cause any of the various allergic reactions (minor to severe) in patients with unsuspected sulfonamide hypersensitivity. There have been isolated reports of serum sickness, periarteritis nodosum, pancreatitis with hepatitis, meningitis, aplastic anemia, thrombocytopenia, drug fever, methemoglobinemia, and cyanosis. Skin rashes, urticaria, and pruritus may occur with its usage. Headache, dizziness, nausea, and, rarely, vomiting have been reported. **HOW SUPPLIED:** No. 786—Each tablet contains sulfamethizole 0.5 Gm. (scored), in bottles of 100 and 1,000.

AYERST LABORATORIES, New York, N.Y. 10017

Ayerst®

7030

Letters

Malpractice Insurance Solution

To the Editor:

The loss of your insurance coverage and the ever increasing higher insurance rates means that the medical profession should look at the etiology of this malpractice dilemma, and use means to cure it, so to speak. At least, that is what the Marion County Medical Society and the Iowa State Osteopathic association decided upon in a resolution last spring directed at our Iowa state legislature.

This resolution goes to the basic cause of our malpractice problem—our archaic state laws which favor the plaintiff in civil litigation over the defendant.

Under our present state laws a plaintiff can make false charges against a physician, and if he loses his case in court he is only out of meager court costs and has no attorney's fee to pay, as such cases are usually handled on a contingent fee basis. But the successful physician defendant who was innocent of the charges brought against him, still has to pay his own attorney's fee. There is no justice in our present state laws in civil litigation, when an innocent defendant may have to pay out, possibly a large sum of money, to prove his innocence in court.

The solution is to change our state laws to make the losing party in civil litigation pay all expenses, including a reasonable fee to the winning party's attorney. This will stop this random suing of physicians.

However, where the plaintiff has a justifiable cause to sue a physician, he is likely to do so, for he will have his court expenses and his attorney's fee paid by the losing party, which in this case would be a physician, or the insurance company. This would be fair.

It has been estimated that with such a state law, 80 percent of our malpractice suits would be eliminated and our malpractice insurance rate would be 50 percent less. We could live with that.

With such a new proposed law for a state there must also be incorporated a provision that the poor man can sue, if he has a legitimate case.

Such a law will not only help physicians, but also dentists, nurses, contractors, engineers, store and home owners, etc.—at least 99 percent of the people, for no one knows when he may be subjected to false accusations.

The law here proposed is not new or untried. It's the law on the statute books of most mid-European countries. They do not have this malpractice problem; nor would we, if we changed our state laws.

PETER VAN ZANTE, M.D.
Pella, Iowa 50219

This has become the law in several states, but its constitutionality is still unsettled.—ED.

To the Editor:

Thank you for the "soapy" Wink comments. They are a very gratifying remembrance of our happy two weeks with you in Hawaii.

Warmest best regards.

RICHARD K. WINKELMANN, M.D.
Rochester, Minnesota 55901

December 7, 1970

To the Editor:

On this Pearl Harbor Day anniversary I send you greetings, and a letter for the JOURNAL, if you can find a place for it.

I know it is quite usual for a doctor to make a trip through Europe and come back and be an expert on national medicine. May I disclaim that pretense or honor. We doctors were on tour of Central Europe and visited health centers in Copenhagen, Denmark; Berlin, Germany; Geneva, Switzerland; Rome, Italy and Vienna, Austria. We found fine new hospitals in Copenhagen, Berlin and Vienna. They are newer and as well planned as most American hospitals, and in many instances financed by U. S. money either through the Marshall Plan or foundations, e.g. Ford. The intensive care units are individual and filled with all the monitoring devices and staffed with many competent young men doing this plus anesthesiology. The grounds about most of the hospitals were beautiful and park like.

In Denmark all but 10% of the population is covered by National Insurance. About 25% of all the tax revenue goes to health care. That was the best estimate we could get. In Denmark the cost of the health care is 6% of their Gross National Product. This is going up steadily. In Austria the cost was estimated at 25% of their tax revenue. They do not like to talk about this phase of socialized medicine. Nurses are scarce in Berlin and the shortage is getting worse.

It is the General Practitioner who is overwhelmed with great numbers of patients. He has no control of the patient in the hospital, although when the patient is discharged from the hospital, he is sent back to the G. P. They often see one hundred patients a day and fill out endless forms. They have no time to study or take most graduate courses to keep up with the advances of medicine as we do in the United States. In all these countries the graduate in medicine must remain four, five or six years to become a specialist. They have no qualifying boards. If there is no place for him in the hospital or in the University set up, he must go into private practice, which seems to them and to us a tremendous waste of training. There are some foreign doctors practicing in their system. In Rome we found that very few reach the zenith, *i.e.*, stay on in a hospital position.

National Health is universal in Denmark, Germany, Switzerland, Italy and Austria. The men queried were not happy with their lot but felt it was their way of life and they could not change it.

In Vienna we were shown a unique Emergency Hospital. It was founded in 1906 by Dr. Lorenz Bohler, now 87. Dr. Bohler, of intramedullary nail fame, still sees patients and lends a hand. He is remarkable in that he is so vigorous. His voice is strong. His hands are supple and strong. His carriage is upright. The insurance companies maintain the hospital. There were 240 full time workers taking care of 170 patients. Herr Professor has a few private patients. They have continuous night and day services for x-rays, anesthesia and all laboratory services. The surgeon must be able to do a craniotomy for a subdural hematoma, handle a torn liver or ruptured spleen, reduce the worst open fracture, or suture a broken vessel. The surgeries are well equipped with every imaginable device, even to intensifying screens. A malpractice suit is unheard of. Physiotherapy has a prominent place. Secretaries do all the case and form work. No surgeon has a lot of writing to do. There are surgeries for clean and dirty cases. On one of the days I was there, they were pinning a hip using the intensifying screen. A new hospital is in the planning stage. I would have to say that their Emergency Hospital was better than any I've encountered anywhere.

Dr. Bohler's son lectured for three hours on their

emergency eare praetiees, namely organization requirement for eare of the severely injured, general prineiples for survival of severely injured in road aeeidents. He also leetured on the newer prineiples of hand surgery. Dr. O. Russee spoke on eompression plate fraetures of the forearm. This is a whole new eoneept and requires speeial tools. He then spoke on supraeondylar fraetures in ehildren. I mention these to give an idea of the seope of this great institution. Later he spoke on fraetures of the navicular bone and his method of surgieal eorreetion.

Also in Vienna we went into the surgeries and saw gastrie surgery, a nerve repair at the wrist, gall bladder surgery and some arterial bypass surgery. It was well done, anesthesia and assistanee were good. Both gut and cotton suture material was used. Eleetroeoagulation was used for eontrol of the nuisanee bleeders. Common duet x-rays were done routinely in gall bladder surgery.

In Switzerland from a previous assistant of Dr. DeBakey's we learned of Fentanyl as an anesthetie agent. Apparently that is the agent of ehoiee of 80% of their surgieal eases.

In Lausanne we were taken to the well stoeked wine eellar for a noon repast. I am heartily in favor of this as an addition to any hospital for staff use.

DOUGLAS B. BELL, M.D.
Honolulu, Hawaii 96814

It would be too bad if the editor of this JOURNAL *could not find a place for a communication from his only predecessor! Dr. Doug Bell was the editor of the* Bulletin of the Honolulu Medieal Soeiety, *and only the pressure of events deterred him from accepting the post as the first editor of the* HAWAII MEDICAL JOURNAL. *We're glad you enjoyed Europe, Doug, and interested to learn that you thought so well of it. Thanks for writing!*—ED.

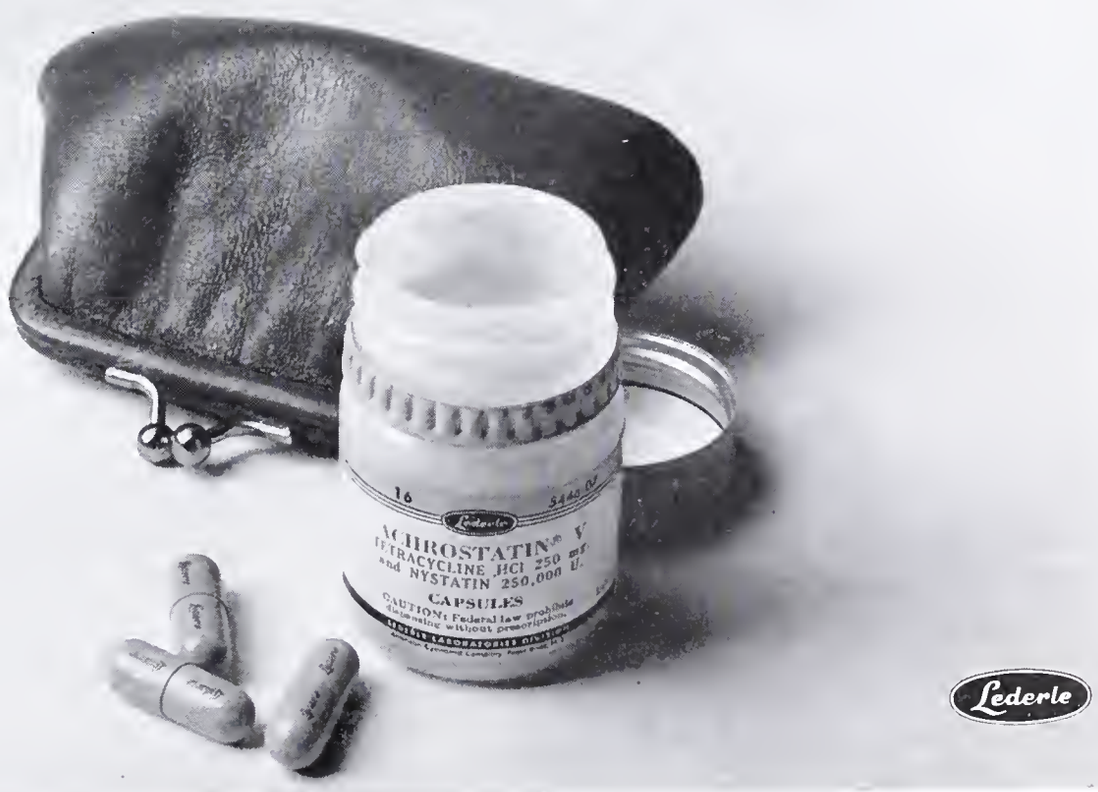
Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

—The lowest priced tetracycline—nystatin combination available—



"I'M FEELING
MUCH BETTER, DOCTOR."

"SO AM I."



HMSA is the "get-well card" that leaves you *both* feeling better. Offers patient and physician lasting relief from medical economic problems. Once again, March, July and November are individual enrollment months. An excellent time to remind unprotected patients about the benefits of belonging to this non-profit community organization. It's good for what ails them. And you.

Hawaii-owned for Hawaii's own
HAWAII MEDICAL SERVICE ASSOCIATION
BLUE SHIELD PLAN FOR HAWAII
Member Western Conference of Prepaid Medical Service Plans

HONOLULU 1504 Kapiolani Blvd., P. O. Box 860, Phone 944 2110
WAILUKU, MAUI P. O. Box 956, Phone 323-912
LIHUE, KAUAI P. O. Box 27, Phone 245-3393
HILO, HAWAII, P. O. Box 1356, Phone 935-5441
KAILUA-KONA, HAWAII P. O. Box 1219 Phone 329-3030

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Controindicotions: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Worning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reoctions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenamena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-103 / 2/71 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed toblet contains: Quinine sulfote, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention ond treatment of nocturnal and recumbency leg muscle cramps, including thase assaciated with orthritis, diabetes, voricase veins, thrombaphlebitis, arteriosclerosis and static faat defarmities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinol cromps in some instonces, ond quinine moy produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discantinue use if ringing in the ears, deafness, skin rosh, or visual disturbances accur. **Dosage:** One tablet upon retiring. Where necessary, dosoge moy be increased to one tablet fallawing the evening meal and one toblet upon retiring. **Supplied:** Bottles of 100 ond 500 tablets.

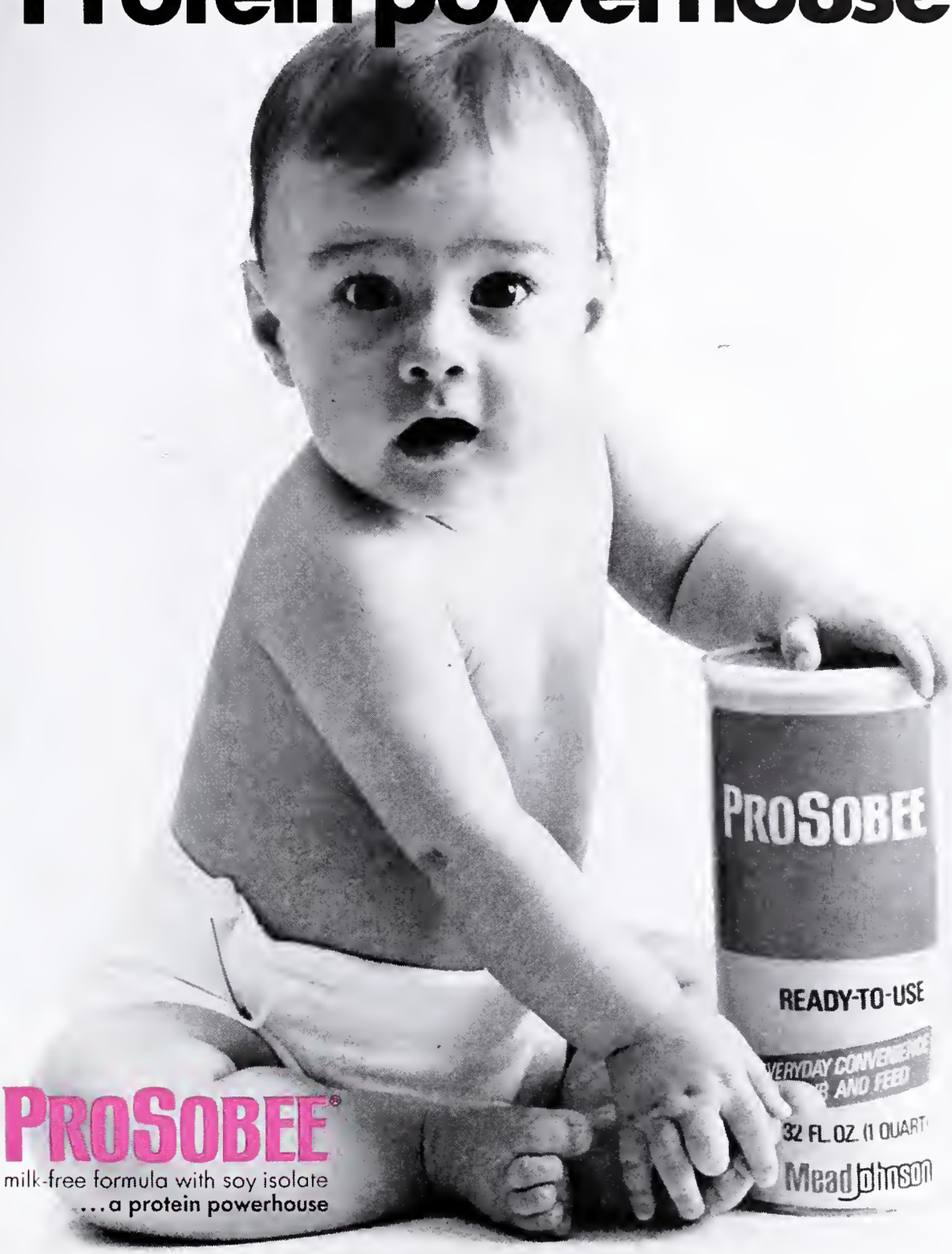


THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

Protein powerhouse!



PROSOBEE®
milk-free formula with soy isolate
...a protein powerhouse

For the "problem feeder" whose serum protein reserves are low—PROSOBEE provides an extra boost of protein to help bring reserves up and help keep them there ❋ 25% or more protein than other soy isolate formulas ❋ milk-like color, smoothness and flavor for greater acceptance ❋ convenient 32-fl. oz. PROSOBEE Ready-To-Use—no chance for mixing error. **For Hospital Use:** NURSETTE® disposable bottles, 4- and 8-fl. oz.; for the BENIFLEX® Disposable Nurser System, 32-fl. oz. cans.

Composition: 87% water, 3.9% sugar, 3.1% soy oil, 2.7% corn syrup solids, 2.7% soy protein isolate, 0.26% dicalcium phosphate, 0.26% potassium citrate, 0.10% lecithin, 0.05% calcium carbonate, 0.04% dibasic magnesium phosphate, 0.03% salt, 0.03% carrageenan, 0.03% guar gum, 0.02% DL-methionine, vitamin A palmitate, calciferol, sodium ascorbate, thiomine hydrochloride, riboflavin, niacinomide, sodium iron pyrophosphate, potassium iodide, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, choline chloride, inositol, cupric sulfate, manganese sulfate and zinc sulfate.

©1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721

77270R

Mead Johnson
LABORATORIES



Not too little, not too much... but just right!

"Just right" amounts of Ilosone Liquid 250 can be dispensed easily from the pint bottle in *any* quantity you specify to meet your patients' precise needs—without regard to package size.

ready-mixed

Ilosone® Liquid 250

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

100204

The Edward D. Churchill Lecture

The dean of Hawaii's surgical profession recalls to mind a half century of experience with gastric surgery and offers some engaging reminiscences of December 7, 1941 and also the Honolulu of 1916. He retires from practice on his 80th birthday, March 6, 1971.

I. Fifty Years' Observation of Gastric Surgery

JOSEPH E. STRODE, M.D., *Honolulu*

Duodenal ulcers are initially a medical problem, and the best method of surgical management for those cases not responding to medical management has not yet been settled. Some advocate vagotomy plus pyloroplasty, others antrectomy and vagotomy. Gastric ulcers should be treated by partial gastrectomy as soon as the diagnosis is made, because (1) medical management is highly unsatisfactory, and (2) there is no way to be sure that they are not early gastric carcinomas, which are likely to pass from a possibly curable phase to a probably incurable one during any period of attempted medical management. Vagotomy should not be performed for gastric ulcers.

NO PART of surgery has claimed my interest and attention over the years more consistently than have surgical lesions involving the stomach and duodenum. I early realized that lesions of this area were relatively common in Hawaii, and investigation over the ensuing years revealed that cancer of the stomach was much more frequent in Hawaii than in the mainland United States. This frequency was determined to arise from the fact that the Islands were peopled predominantly by Japanese, in whom, both locally and in Japan, cancer of the stomach occurred two to three times more frequently than any other of the races in Hawaii.

While the observations I have made of gastric surgery cover more than fifty years, they have largely been accumulated since 1922, when I became a member of the Straub Clinic. Since that time my associates and I have had occasion to subject to surgery more than 2,000 individuals with lesions of the stomach and duodenum. These lesions have been fairly equally divided between duodenal and gastric ulcers, and carcinoma of the stomach, with congenital hypertrophic pyloric stenosis, gastric polyps and other benign tumors, prolapsing gastric mucosa, gastric diverticula, hypertrophic gastritis, and other conditions playing a much less important role.

At the time of my graduation in medicine in 1915, the most frequent operation for benign lesions of both the stomach and duodenum was gastroenterostomy. This could be done with a low

Read before the Excelsior Surgical Society, Kaanapali, Maui.
Received for publication November 1, 1969.
From the Department of Surgery, Straub Clinic, Honolulu.

mortality even by surgeons of limited surgical experience, and, in many instances, the results proved satisfactory. It became a frequent, almost fashionable, operation for all types of disorders that were thought to arise in either the stomach or duodenum. Symptoms rather than x-ray and fluoroscopic evidence of an organic lesion were usually the basis for this decision. Wölfler in 1881 (just 10 years preceding my birth) originated gastroenterostomy in the treatment of carcinoma of the stomach and Rydygier[7] three years later introduced this procedure for the treatment of duodenal ulcer, this being the first operation used in the treatment of this condition. It took the next 40 to 50 years to convince most surgeons that there were other operations that gave much better results.

In the early 1920's, following published reports of von Haberer, Beers, Fenster, Bastinanelli, and other European surgeons along with those of Lewisohn, Berg, Lahey, Strauss, and others in America, calling attention to the high rate of recurrent ulcers following gastroenterostomy, gastric resection gradually supplanted that which was originally thought to be a more conservative operation.

I vividly recall, at a meeting of the New York Surgical Society in October, 1925, hearing Doctor Lewisohn present a paper on "Failure of Gastroenterostomy to Effect a Decisive Reduction in Gastric Acidity."[5] He reported an incidence of 34% gastrojejunal ulcers following gastroenterostomy for duodenal ulcer, of which 18% were proved by operation and 16% by symptoms and x-ray findings. His conclusions and recommendations were that subtotal gastrectomy should be the operation of choice for both gastric and duodenal ulcers. In the discussion that followed this presentation, criticism was most scathing. The idea of removing a large part of a normal-appearing stomach in order to cure a lesion in the duodenum, only a few millimeters in diameter, sounded preposterous, even bordering on malpractice.

In the years that followed it became the experience of every one interested in this type of surgery, that gastric resection for both gastric and duodenal ulcers gave end results far superior to those obtained by gastroenterostomy. This observation resulted in most surgeons' removing from 70 to 80% of the stomach for duodenal ulcer. It also soon became apparent that the greater the amount of the acid-secreting part of the stomach that was removed, the fewer the recurrent ulcers; but the greater was the number of distressing, and at times disabling, symptoms that ensued. Thus one was forced to sail between Scylla and Charybdis in attempting to balance the danger of recurrence against the prospect of a less serious but more frequent disabling sequela, known as the dumping syndrome.

While the cause of gastric and duodenal ulcers has never been conclusively established, depending as they no doubt do on many and varied factors—even varying with individuals—it is unanimously agreed that gastric hyperacidity plays the dominant role. Until Dragstedt and Owens[3] in 1943 advocated truncal vagotomy, later adding a drainage procedure in the treatment of duodenal ulcers, we had only one method at our disposal with which to make a hyperacid stomach permanently anacid. Such a method was by partial or subtotal gastrectomy.

It has been amply demonstrated by many investigators, credit largely belonging to Dragstedt, that duodenal ulcers are associated with hypersecretion from vagal stimulation of central or cephalic origin. Vagotomy results in eradicating hypersecretion from this source but results in hypomotility of the stomach, necessitating a drainage procedure, either gastroenterostomy or pyloroplasty, to prevent gastric retention. Vagotomy plus pyloroplasty, using the Weinberg technique of one-layer closure, seems to be gaining in popularity, but many prefer antrectomy and vagotomy, maintaining that fewer recurrent ulcers follow this operation.

However there still remains a hard core of recalcitrant surgeons who speak with great authority and who do not believe in vagotomy for this condition but continue to do high gastric resections. Alton Ochsner, Owen Wangensteen, and Jim Clagett come to mind as being opponents of vagotomy.

In the late 1920's Devine[1, 2] of Melbourne, Australia, advocated gastric exclusion in the selective treatment of duodenal ulcer, stating that the more stomach that was excluded, the greater the anacidity produced. This procedure appealed to me at the time, and it was used in twelve cases, but further experience came to an abrupt termination when one patient—ten weeks postoperatively—died of peritonitis due to a ruptured stomal ulcer. During this time I had used this exclusion procedure in an individual 18 years of age who five years previously (at the age of 13) had a gastroenterostomy for a duodenal ulcer and who had developed a stomal ulcer. I lost track of this individual following the operation, but 19 years

later he wrote me from California that he had no more epigastric distress and was trying to persuade one of his friends, with trouble similar to what he previously had, to come to Hawaii and have the same operation. Fortunately for all concerned, no doubt, he never showed up.

Some of you were at the recent meeting of the American Surgical Association in Cincinnati and heard Doctor Tedric and associates discuss gastric exclusion in the treatment of extreme obesity and in selected cases of duodenal ulcer. Lloyd Nyhus, as you may recall, said that in his opinion this operation should never be used in the treatment of duodenal ulcers. I wrote to Doctor Dragstedt for his opinion, which is as follows:

> The questions you raise are of great interest from the standpoint of gastric physiology. The exclusion operation performed by Finsterer and Devine was bad because it led to a very high incidence of gastrojejunal ulcer. The cause of this high incidence remained in doubt for many years. During the course of our studies on the physiology of gastric secretion, we found that acid in contact with the antrum mucosa stops the release of gastrin, and so inhibits the gastric phase of secretion. When the antrum is excluded, as in the Finsterer-Devine operation, it is shielded from contact with acid and consequently, acid inhibition of gastrin release does not occur. If food then regurgitates through the duodenum into the excluded antrum, it can cause a long continued stimulation of gastric secretion. Some years ago Dr. Kay of Glasgow thought he could improve the exclusion operation by excluding a considerable amount of the acid secreting fundus along with the antrum. He employed this operation in a number of patients, but abandoned it because it caused a high incidence of gastrojejunal ulcer. The Iowa surgeons, however, in their attempt to treat both obesity and duodenal ulcer, have excluded a very much larger portion of the body and fundus of the stomach than did Dr. Kay. This acid flowing over the antrum has apparently been sufficient to prevent the release of gastrin and the exclusion of such a large part of the stomach from gastric digestion has caused these patients to lose a large amount of weight. I believe this is the reason why the Iowa surgeons have not encountered the stomal ulcers that Kay encountered, or the previous surgeons who used the exclusion operation. I suspect that the young man of 18 on whom you excluded both the antrum and a portion of the body of the stomach got a good result because there was sufficient acid in contact with the antrum so that release of gastrin was prevented.

I have been impressed over many years with the apparent lack of appreciation by many physicians of the differences between gastric and duodenal ulcers, as regards both their etiology and their treatment. Many essayists speak of "peptic ulcers" and make no differentiation between ulcers involving the stomach and those involving the duodenum. A peptic ulcer may be defined as a benign nonspecific ulcer located in that portion of the alimentary tract bathed by gastric juice. Duodenal ulcers are practically never malignant but a gastric ulcer should never be classified as a peptic ulcer until after careful examination of the entire lesion by a competent pathologist. Roentgenologists especially should refrain from reporting their findings as showing a peptic ulcer of the stomach. To do so tends to lull the physician responsible for the patient's care into a false sense of security.

Investigative work and clinical experience indicate that gastric ulcers arise from an entirely different mechanism than duodenal ulcers. The evidence seems quite conclusive that gastric ulcers result from overstimulation of the antral mucosa by food, causing increased formation of a hormone, gastrin, which is absorbed into the blood stream, resulting in stimulation of the parietal cells of the glands of the body and fundus of the stomach to over-produce hydrochloric acid. Any condition giving rise to hypoperistalsis or obstruction to the outlet of the stomach is prone to give rise to a gastric ulcer by prolonging contact of food with the antral mucosa. A clinical observation tending to corroborate this belief is the occurrence of gastric ulcers, secondary to duodenal ulcers, in 15% or more of the cases, the gastric ulcer being attributed to pyloric obstruction, being either organic or due to spasm. Another clinical evidence is the fact that antrectomy alone has proven so effective in the treatment of gastric ulcers.

Everyone, I am sure, agrees that duodenal ulcers are initially a medical problem. Most such ulcers respond well to conservative measures in individuals who are cooperative. On the other hand, I am convinced that, with few exceptions, gastric ulcers belong in the province of the surgeon once the diagnosis has been made. This opinion is based on the fact that gastric ulcers respond poorly to medical measures, in that they are nonresponsive to permanent cure in from 30 to almost 100% of the cases that have been reported. The mortality from hemorrhage, perforation, overlooked malignancy, and other complications exceeds that of surgical removal by competent surgeons. This is a fact not appreciated by many. Removal of such ulcers by gastric resection, in our hands and in the experience of many others, has been found to be a most satisfactory procedure because the mortality is low, complications few, and end results are, with few exceptions, gratifying to the patient and surgeon alike.

While the incidence of cancer of the stomach is decreasing throughout the United States, it is

also, still, a factor always worthy of consideration. No one, with diagnostic methods presently available—which include history, physical examination, x-ray and fluoroscopic examination, gastroscopy, and cytological examination of exfoliated cells—can be sure that any given ulcerating lesion of the stomach is not malignant. This can only be determined by the pathologist having the entire specimen to examine.

The great majority of internists and gastroenterologists recommend and practice observation of such patients for a period under medical treatment to see if the ulcer will heal. I am sorry to say that a number of surgeons—whose experience should teach them otherwise—condone this method of approach to this problem. I am not speaking of patients who are poor operative risks or have acute ulcers secondary to various medications, or who suffer acute, transitory ulcers secondary to stress. I am speaking of the rank and file of individuals with this condition who are seen in our daily practice. I am opposed to any form of medical therapy, because years of observation of the natural history of this disease substantiate the fact that conservatism is so ineffective. A short period of intensive medical treatment usually results in alleviation of symptoms and at times disappearance of the crater even though the lesion is later proven to be malignant. We have had sufficient exposure to cancer of the stomach in Hawaii to convince ourselves that the only opportunity we have to cure an individual with this disease is during its incipiency, while the lesion is localized to the gastric wall or to the immediate lymph nodes. It is during this period, in which our medical brethren are dilly-dallying, with the hope of seeing evidence of healing, that the surgeon has the best (and, many times, the only) opportunity of curing the patient if the ulcer is on a malignant basis.

Until comparatively recently, the more or less standard treatment for gastric ulcer has been gastric resection. With the recognition of the role vagus nerves play in the genesis and treatment of duodenal ulcers, some have incorporated vagotomy in the treatment of gastric ulcers. My observations, particularly the experience gained without its use, lead me to believe that such a procedure is not only unnecessary but is contraindicated. Why add a vagotomy to gastric resection, when observation of over 700 cases in which such a procedure was not used disclosed only three recurrent ulcers, none of which were associated with a demonstrable duodenal ulcer?

Part of the general enthusiasm stems, no doubt, from reports by some investigators that complete removal of vagus stimulation diminishes the release of gastrin, not only from the antrum but also from the small intestine, as well as diminishing the sensitivity of the parietal cells to stimulation by gastrin. Be this as it may, our experience has shown that since removal of the antrum alone has given such good results, we are not encouraged to add any ancillary measures. Vagotomy is not an innocuous procedure, either in the immediate complications that may result or in the frequent, and at times distressing, effects it may have on other visceral organs.

From my experience, rarely does one need to remove more than 50-60% of the stomach to include a gastric ulcer, and comparatively few individuals with this amount of stomach removed suffer postgastrectomy symptoms of a permanent nature. The advantages of vagotomy and a drainage procedure have yet to offer statistics favorably equaling that of gastric resection. I am never satisfied that four-quadrant biopsy of the wall of the gastric ulcer will rule out the possibility of overlooking a malignant lesion.

In our experience at the Straub Clinic in more than 2,000 operations for gastric and duodenal lesions, excluding congenital hypertrophic pyloric stenosis, only seven such lesions have occurred in infancy and childhood. Three of these individuals had duodenal ulcers. One infant at the age of 9 months bled so severely and continuously that ligation of the bleeding vessel became necessary. It seemed advisable to do a subtotal gastric resection rather than try to convert the long incision across the pylorus into a pyloroplasty. This operation was done in October, 1949; the patient made a good recovery and is now a husky Marine fighting in Viet Nam. In 1931 a boy of ten was subjected to gastroenterostomy for a duodenal ulcer causing pyloric obstruction. Seven months later he had developed a large stomal ulcer necessitating high gastric resection to effect a cure. He made a good recovery, and the only time I have seen him since, he was 22 years of age, over 6 feet tall and well-nourished, and had experienced no further epigastric distress. I have often wondered since then if my efforts had been worthwhile as at that time he was acting as a procurer in a house of easy virtue. The other duodenal ulcer case had a gastroenterostomy at age of 13, developed a stomal ulcer and was subjected to a Devine type of gastric exclusion at age 18. Nineteen years later he continued to be well.

Two cases of neonatal gastric perforation are included in this young age group, one of whom lived and one died following operation. The surviving patient, a premature Japanese girl, was operated upon at age 4 days, on May 21, 1951, because of abdominal distention and an x-ray showing free air in the peritoneal cavity. She is now well at age 18 years. As far as I have been able to determine, this is the third patient to survive such an operation. It is interesting to note that this condition was first described in 1826 by von Siebold, an ancestor of Doctor Straub, the founder of our Clinic. Since the first description of this condition, more than 150 cases of so-called spontaneous perforation of the stomach in the newborn have been reported. No one has had an extensive experience with this condition, which emphasizes the rarity of its occurrence. There is much difference of opinion regarding the etiology of neonatal gastric perforations. Some maintain that it is evidence of congenital muscle defect and others, the result of trauma. Experimentally, increased intragastric pressure has been shown to produce gastric perforation, resulting in the same histological pattern of the muscle in the gastric wall as found by those suggesting a congenital defect.

One case was a boy of 14 with a large gastric ulcer along the lesser curvature. He was subjected to gastric resection because of acute epigastric tenderness indicating impending perforation, and a social environment incompatible with proper medical treatment. The seventh case was a 14-year-old girl with a large ulcer crater of the stomach which, after total gastrectomy, was found to be a small-round-cell lymphosarcoma. The patient did not survive long following surgery.

No doubt the incidence of peptic ulcer disease in infancy and childhood, particularly duodenal ulcer, is much higher than generally recognized. More frequent resort to x-ray examination with better equipment has brought many more such lesions to light in recent years.

Swenson, in his book *Pediatric Surgery,* published in 1962,[8] stated that one reason for the conservative attitude of physicians and surgeons toward surgical treatment of lesion of the stomach and duodenum in children is our limited knowledge concerning the fate of the child following subtotal gastrectomy.

Raffersperger[6] and associates of Cook County Hospital in an article appearing in December, 1966, stated that a surgeon called upon to treat an infant with a bleeding peptic ulcer has few data upon which to base his decision for therapy.

It would appear that, from our ever-broadening experience, when such lesions occur in infancy and childhood, and where surgery is indicated, they should have the same type of operation as that being used in adults for similar conditions. The fear that children and infants will not develop normally following gastric resection has been demonstrated to be fallacious.

In Hawaii, as previously stated, we have had the opportunity to observe individuals with carcinoma of the stomach with greater frequency than in other parts of the United States. We have not learned why the Japanese are more prone to this disease than are other races. I understand from our Japanese colleagues in Japan that its incidence there is not decreasing as it has in recent years in continental United States. We believe that it will be interesting to determine more accurately in the future, whether Japanese born in Hawaii will have the same incidence of cancer of the stomach as occurs in our other races. At least at present that seems to be the trend, but further observation is necessary. The most logical conclusion, it would seem, is that there is a carcinogenic agent in the diet of Japanese in Japan which is not present in the diet in the western part of the world.

Our experience in Hawaii, like that elsewhere, is that cancer of the stomach is a very lethal disease, and that the only hope for cure lies in early recognition and surgical removal. Our best results have followed surgery when the lesion was thought to be benign and proved to be malignant. In such cases the five-year survival rate has been about 60%, and some of these patients have lived for 30 years following surgery. In our experience the overall five-year survival rate for all cases subjected to surgery has been around 13%. We have not been impressed with attempts to salvage such patients by super-radical surgery. This is one of the reasons why we are so insistent that all ulcerating lesions of the stomach be removed without delay.

Gentlemen, this completes what is but a brief summary of my fifty years' observation of gastric surgery. I hope, and believe, we in Hawaii have kept abreast with advances that have been made in the surgical treatment of gastric and duodenal lesions, and I believe our mortality and end results compare favorably with those being reported by clinics elsewhere which are equally interested in these problems.

II. My Experience at Pearl Harbor at the Time of the Blitz, December 7, 1941

December 7, 1941, was a time of intensive excitement and alarm during which traumatic surgery had to be practiced under extremely unfavorable conditions because of inadequate preparations' having been made.

THE SECOND phase of my address is directed to the experiences I had during and subsequent to the attack by Japan on Pearl Harbor on December 7, 1941.

It became apparent early in 1941 to the civilians living in Hawaii that due to the ever-increasing aggression of Japan, the United States would in all probability soon become involved in war. We realized that in this event Hawaii would be in a most vulnerable position, and that we physicians should prepare ourselves to take care of large numbers of wounded should an attack occur. To this end, the Honolulu County Medical Society, early in 1941, appointed a committee to assign doctors and nurses to hospitals and first aid stations, to form ambulance corps and train civilians to help take care of the wounded, an important aspect of such preparation. It was also deemed advisable to secure advice and counsel from an authority on the most modern developments in the care of wounds. For this purpose Doctor John J. Moorehead of Postgraduate Hospital of New York City, a noted traumatologist of that era, was engaged to give us a series of lectures.

Sunday morning, December 7, 1941, was an exceptionally clear and beautiful day, and I had risen early in order to take care of an emergency appendectomy preceding Dr. Moorehead's lecture at 9 o'clock. On completion of the operation I joined a number of physicians who were on their way from Queen's Hospital to the Mabel Smyth Auditorium nearby, where the lecture was to be held. They were concerned about activity taking place in the direction of Pearl Harbor and commented on the unusual activity of the Air Force, especially for a Sunday morning. One physician who had gone to the roof of the hospital and looked in the direction of Pearl Harbor reported that he could not decide what was taking place but from the number of planes circling about and explosions that could be seen throwing water high in the air and smoke rolling out in great quantities, it looked as though all Hell had broken loose.

In a state of quandary we proceeded on to the lecture and, upon our being seated, Dr. Moorehead began his lecture with these most appropriate and prophetic words taken from the Bible (Matthew 24:42): "Be ye also ready, for in such an hour as ye thinketh not, the son of man cometh." At that moment, the doors of the auditorium were thrown open and one of our physicians, in a very excited manner, proclaimed that Pearl Harbor was being bombed and all available physicians were needed immediately at Tripler General Hospital.

With Dr. Moorehead in my car we made a precipitous departure for Tripler Hospital, approximately 5 miles away.

Knowing a short cut to the hospital through adjacent Fort Shafter, I started that way but was abruptly halted by a sentry who said we could not enter. Dr. Moorehead, assuming a very military bearing, stated he was a Colonel in the United States Army and flashed a badge to back this up, and after this we met no further opposition. Dr. Moorehead later confessed that the badge was a pass on the Transportation System of New York, he being a surgical consultant to that organization.

Tripler Hospital was an old frame structure, located about two or three miles nearer to town than the present magnificent edifice, and a few miles from Pearl Harbor. It was totally unfitted for taking care of the great mass of casualties we found in and around it on our arrival. The operating rooms, the corridors, the lanais and the surrounding grounds were filled with a mass of severely wounded, dying, and dead. Every conceivable type of wound was apparent. Some individuals had one or more extremities blown away. There were severe head injuries. There were sucking wounds of the chest. Some had their intestines hanging out of gaping wounds of the abdomen. It immediately became apparent that many of the individuals were beyond mortal help. Some had the possibility of being saved under more favorable circumstances, and others needed immediate attention to stop hemorrhage. Some could wait a period of time without too much risk. There were no facilities available to segregate the wounded

into the categories mentioned, and very little with which to treat anyone for shock if there had been the opportunity. There were six operating rooms on the second floor reached by a winding staircase, and only one elevator in the vicinity.

The civilian doctors quickly replaced the military personnel at the operating tables, since the latter could be more efficiently used in other parts of the hospital. We had practically no trained anesthetists; most of the anesthesias were drop ether given by nurses. We lacked orderlies to move the patients. We quickly used up what meager sterile supplies were available and no one seemed to know where to get any more. We ran out of instruments, needles, suture materials, and the like. We had no help to get the patients on and off the operating table and no one to remove patients' clothing or clean up the wounds. Everything was confusion. The wails and groans of the injured blended with the roar of planes overhead. The rat-tat-tat-tat of machine gun fire and the explosions of bombs, some of which pierced the roof of the building and landed on the operating floors, made us realize that we were in a somewhat precarious situation. One of the doctors who had parked his car near the hospital later found it riddled with machine gun bullets.

Because everyone was so completely occupied, no reliable information could be had as to what was happening on the outside. Rumors were rampant that the enemy troops had landed and were ransacking the city, and we would all soon be prisoners of war. We were all naturally very apprehensive as to what was happening to our families. As the day wore on the hospital's reserve supply of sterile linen and instruments was located, and the Red Cross also came to our rescue with loads of supplies. Nurses were recruited from the local hospitals and we were able to get more nonprofessional help, but the most life-saving commodity of all, blood, was not available. A blood bank had just been started at Queen's Hospital but the few liters of plasma that had been accumulated lasted as long as the proverbial snowball.

Doctor Moorehead and I frequently consulted with one another and with the other surgeons as to whether a leg or an arm should be amputated or an attempt be made to save it; how nerve injuries should be handled and what to do with some of the extensive injuries of the chest and abdomen. Doctor Moorehead was a tower of strength throughout the most acute phase of the care of the injured and he stayed on for many days thereafter not only advising in the care of military injuries but injuries of the civilians as well. I am sure his wide experience in handling the severely wounded and his sound judgment saved many a life and limb and for which, due to the chaos and confusion, he was never given adequate credit.

Many of the injuries we saw were of a bizarre and unusual nature. One case stands out in my memory because I had never seen a similar one before and have never seen one since. A few hours previously the individual had received extensive wounds of his chest from an exploding shell and at the time I saw him, he was completely emphysematous from the top of his head to the soles of his feet. The skin was so tightly stretched, it seemed ready to burst at any moment. He was deeply cyanotic, gasping for breath, thrashing about on the bed and imploring those about him for help. Aspiration of both sides of the chest revealed no tension pneumothorax. It suddenly dawned on me that he must have had an injury to his mediastinal trachea or bronchi to give such a picture. A wide slash with a scalpel without anesthesia, across the structures just above the sternum gave spectacular results. Frothy fluid under great pressure squirted out and ran down over his chest in a steady stream. The patient experienced immediate relief and respirations became regular and normal, the cyanosis cleared up and the patient expressed himself as deeply grateful for the help he had received. We realized the seriousness of his injuries and the magnitude of surgery that would be required to offer hope for recovery. So, as the fortunes of war dictate, one must ever face reality. We turned our attention to other seriously wounded for whom our efforts offered a better prognosis. I was told some time later that this patient did not long survive.

After working continuously from 9:30 a.m. to about 9 p.m. under the trying circumstances which I have mentioned, we were so completely exhausted both mentally and physically that we could no longer function efficiently. Most of the acutely injured had been taken care of and new doctors were arriving to carry on. Those who under more ideal circumstances might well have been saved had gone to the great beyond. A number of us were returned to our homes in a military vehicle in utter darkness, challenged at every block by trigger-happy sentinels. Luckily, we arrived home without mortality after about three hours, normal time taking about 20 minutes. Our driver had orders to keep all car windows closed and he believed in following orders implicitly, so our ride resulted in near suffocation. We arrived home too tired to eat, move, or sleep.

For the following ten days, I took part in the care of these patients postoperatively, and I was agreeably surprised to see how few exhibited evidence of serious infection. We had at our disposal an unlimited amount of sulfanilamide powder, and at the time of surgery we used it in wounds in virtually unlimited amounts.

While everyone in Hawaii was ill prepared to cope with the great mass of seriously wounded with which we were confronted, we quickly learned how to improve the situation should a subsequent attack take place. Fortunately this never occurred. I have often thought since what a tremendous improvement in the care of the wounded that day would have been possible had the present magnificent structure of Tripler General Hospital with its many facilities and outstanding staff been available. There would have been the opportunity to segregate those needing immediate surgical attention from those first needing treatment for shock and from those who could have been taken care of more-or-less electively. Certainly blood, the most important therapeutic agent under such circumstances, would have been freely available to those most in need of it.

Some months after the blitz, Norman T. Kirk, Surgeon General of the Army at that time, invited all the physicians in Hawaii to a meeting at which time he thanked the civilian doctors for the assistance they had given in caring for the military personnel. He admitted that the civilians had been better prepared to meet the emergency than had the military forces. Doctor Moorehead, having meanwhile been created a Colonel in the Medical Corps, remained in Hawaii for a number of weeks following the blitz and contributed tremendously in helping to solve a number of problems, not only those arising in the military area but in the civilian sector as well. On Christmas Eve, December 24, 1941, he wrote "A Surgeon's Prayer in Wartime" which to my mind was most appropriate and worth reading at this time.

God of Battle, grant that the wounded may swiftly arrive at their hospital haven so that the safeguards of modern surgery may surround them to the end, that their pain is assuaged and their broken bodies are mended.

Grant me, as a surgeon, great skill and intelligent foresight to bar the path to such assorted enemies as shock, hemorrhage and infection.

Give me plentifully the blood of their non-combatant fellow man so that their vital fluid may be replaced and thus make all the donor people realize that they too have given their life blood in a noble cause.

Give me the instruments of my calling so that my work may be swift and accurate but provide me with resourceful ingenuity so that I may do without bounteous supplies.

Strengthen my hand, endow me with valiant energy to go through day and night and keep my heart and brain attuned to duty and great opportunity.

Let me never forget that a life or a limb is in my keeping and do not let my judgment falter. Enable me to give renewed courage and hope to the living and comfort to the dying. Let me never forget that in the battles to be won, I too must play my part to the glory of a great calling and as a follower of the great physician. Amen.

As I look back on the debacle of December 7, 1941, it seems inexcusable that our military forces should have been caught so completely off guard and that so much of our fleet had been allowed to be bottled up in Pearl Harbor, sitting ducks for the sneak attack so artfully carried out by the Japanese. It resulted in terrific loss of life and limb, principally to our young military personnel, but fortunately to a lesser extent to our civilian population to say nothing of the destruction of our fleet of which we immediately became in need so urgently. It resulted in the worst Naval catastrophe in the history of our nation, for which we should bow our heads in shame. Even though it was a terrible price to pay, I can conceive of nothing that the Japanese could have done that would have more quickly united the entire United States in one resolve—to avenge Pearl Harbor. Let us hope and let us pray that the sacrifice made that day has taught us a lesson never to be forgotten, "Be ye also ready, for in such an hour as ye thinketh not . . ."

Before concluding these remarks on the blitz of Pearl Harbor, I would like to take this opportunity to correct the statement I have heard made that our local Japanese before and after this attack gave aid and comfort to their mother land.

Extensive investigation never disclosed a single instance of proven disloyalty by the Japanese residing in Hawaii. The 100th and 442nd battalions, composed entirely of Nisei, our Senator Dan Inouye being one, made an outstanding record during the war, of which all of us should be extremely proud. If our present dissident races made a similar approach toward demonstrating their worthiness as good American citizens most of the turbulence arising from this source would vanish.

Gentlemen, the remarks made up to this time have been of a rather serious nature. I hope my remaining comments are more in keeping with the spirit of Hawaii—to help you to forget your troubles and responsibilities and to relax and enjoy life to its fullest.

III. The Practice of Medicine in Hawaii in June, 1916

Medical practice in Hawaii in 1916 was primitive, and many amusing incidents are recalled which enlivened it from time to time.

I NOW wish to describe the practice of medicine as I found it on my arrival in Hawaii in June, 1916. I will attempt to portray some of the rather unusual customs and practices prevailing at that time. The practice of medicine then was much like that which people are receiving in the more remote South Pacific islands today.

There were many reasons why I had decided to come to Hawaii—the principal one being the urging of Dr. Jay M. Kuhns, a medical school classmate who had lived most of his life in the Islands. Before and after graduation I had spent 1½ years as a surgical intern at Barnes Hospital before coming to the Queen's Hospital, now known as the Queen's Medical Center. The Queen's Hospital was called by that name in honor of King Kalakaua's wife, Queen Emma, foster daughter of Dr. T. B. Rooke. In 1860 their majesties decided the kingdom was sorely in need of an institution in which to care for their ill subjects. They initiated a drive to raise funds to erect such a structure. We are told that $15,000 was raised and was used to erect the first building whose walls were constructed of coral. These old buildings were still in use on my arrival, but none of them still remain. The bed capacity at that time was about 150. When the construction now underway is completed the capacity of this hospital will be over 600.

I found upon my arrival—somewhat to my dismay—that there was no laboratory. A microscope was available and we could do blood counts and urinalyses, and there were some culture media available, but that was about it. In the absence of an incubator, I remember strapping culture tubes beneath my clothing by day—or pajamas at night—and this human incubator proved successful in isolating typhoid bacilli, from a patient suspected of having typhoid.

For an x-ray, there was a small induction coil capable, on a clear day and when the wind was in the right direction, of demonstrating a fracture of a finger if the fragments were sufficiently separated.

The isolation ward always contained a number of typhoid patients, with their usual complications of hemorrhage and intestinal perforation. Beriberi among imported Filipino laborers was very common and the inability of the patient to jump over a broom stick lying on the floor was supposed to clinch the diagnosis. Amebic dysentery and amebic abscess of the liver then were very common but now are rarely, if ever, seen. The standard treatment for amebic dysentery was an enema of pure kerosene. It worked almost without exception but, of course, we were careful to keep the patient away from an open flame. Malaria was never a problem and is never seen in these Islands except in an occasional imported case, for it is not propagated, since we have no Anopheles mosquitoes. There has never been an authenticated case of rabies in Hawaii, though about two years ago there was much publicity to the effect that this had occurred. We have had for years a four-month quarantine on all animals entering the state, for this reason. Snake antivenin is never stocked locally, because we have no snakes.

At the time of my arrival any medical graduate who was able to pass the territorial examination had the privilege of attempting any type of surgery his conscience permitted. I am sorry to say that there was little evidence of self-restraint in this regard in some instances. Two surgeons here were what I considered to be outstanding for that time, and from them I learned a great deal. From the others, I learned what not to do. In many ways, I believe I learned more from the latter. There were only two specialists, both limiting their practice to eye, ear, nose, and throat diseases. Everyone else was a general surgeon in the true sense of the word.

There were no cystoscopes available at that time and I recall diagnosing a case of urinary tuberculosis and not being able to determine which kidney was involved; we decided to explore what we believed to be the uninvolved side and if it seemed grossly normal, then we would investigate the other side. This worked out exceptionally well as the first kidney seemed perfectly normal and

the second one badly diseased. The patient lived many years following nephrectomy and died of other causes.

There was an excitable old German physician who had developed quite a practice, not because of his professional ability but (as you all have no doubt observed, not too infrequently) because of his jovial and friendly disposition. One day he asked me to assist him with a pelvic laparotomy. With one fell swoop of the scalpel he cut through the entire abdominal wall and, peering down into the interior of the abdomen, his aplomb was somewhat shaken when he discovered a large uterine fibroid. He said to me, "now, Doctor, what will we do next?" I suggested that a hysterectomy seemed to be in order, whereupon he said that since he had had so much experience with this condition and I had had so little, he wanted me to take over the situation. By such generosity, during my early years, I gained considerable surgical experience, not only from this individual but from others who were equally unprepared to deal with the surgical problems they at times attempted to correct. I am afraid the American Board of Surgery would not approve of this method of training at the present time.

On another occasion this same physician was delivering a baby. After its arrival the mother developed a severe hemorrhage. I received an S.O.S. call to give the patient an anesthetic. On arrival I found the good doctor to be in a high state of confusion, violating all principles of asepsis. He decided the uterus should be packed with gauze but before introduction, it should be soaked in vinegar. An attendant was dispatched posthaste to secure the vinegar bottle from the dining room table. With this adjuvant added to the gauze, the uterus was packed, and the uterine packing accomplished its purpose remarkably well. The mother and daughter made an uneventful recovery and joined the ranks of boosters of the good doctor as being an outstanding obstetrician.

One more account of my jovial friend and I will let his soul rest in peace. One day I was in the admitting area of the hospital and I heard the screeching of brakes followed by rapidly approaching footsteps and the clanking of metal. Here was my good doctor again, dragging or partially carrying a young man with a dozen or so hemostats hanging from his neck, with blood covering his shirt and trickling down his arm. The patient was immediately taken to the operating room. Fortunately the great vessels of the neck had been spared and the remainder of the tumor, the removal of which had been attempted in the office, was successfully enucleated. Though its nature was never determined, since there was no pathologist available, I have often wondered from its location if it was a carotid body tumor. At least it was benign, since a number of years later this same individual consulted me for another condition and I inquired as to how he got the rather marked scar on his neck. It then developed that he was the subject of the episode just related. "You know," he said, "Hawaii suffered a great loss when this surgeon decided to move to San Francisco." "Well," I said, "we must not be selfish in such matters. If it's our loss, it is California's gain."

Soon after I arrived, I learned that there was considerable dissension among the doctors. Dr. George Straub, the founder of our Clinic, was particularly resented. He was a graduate of Heidelberg, who had had his surgical training in Germany and New York, and was a man of an unusual ability and resourcefulness. There was no operation he had ever heard of, or that his ingenious mind could devise, that he would not attempt, usually with a successful outcome. He was called to take over a patient in the hospital who had sustained a compound fracture of the tibia. The patient had dismissed his first physician because he did not think he was progressing favorably. I accompanied Dr. Straub when he first examined the patient. Lo and behold, when the dressing was removed the wound was found to be alive with maggots. At that time the therapeutic value of maggots in such wounds had not been appreciated or recommended. Dr. Straub, never being known for his diplomacy, expounded vociferously and at great length to all within hearing distance about what a horrible mess the leg was in. The former physician, when he heard of this outburst (and they not being friends anyway, for previous similar reasons) challenged Dr. Straub to a duel in Punchbowl, an extinct volcanic crater behind the hospital; weapons were to be of his selection. Why this encounter never came about I never learned. It was not, I am sure, because of Dr. Straub's being a coward, for my long association with him in subsequent years convinced me he was unafraid of the devil himself.

During my stay at Queen's Hospital, Dr. Kuhns moved to Kauai to become a physician on one of the sugar plantations. He was very fond of giving anesthetics but had an aversion toward doing surgery. He wrote me that if I could get away he would save up all the elective cases in his district needing surgery and he would take care of the anesthesia if I would do the surgery. He had

a small but fairly well equipped plantation hospital. Fortunately, I was able to spend 10 days with him, during which time we had a field day doing cholecystectomies, gastroenterostomies, and hysterectomies, repairing hernias, and the like. One individual had been going about on crutches for several years with what had been diagnosed as tuberculosis of the knee. Jay and I concluded it was a displaced semilunar cartilage. This was removed, the knee regained normal function, and the patient, for many years after I began practice in Honolulu, was responsible for many surgical cases coming my way.

During World War I, in the fall of 1917, I entered the Army Medical School in Washington, D.C. and after graduating spent the remainder of my military career in the base hospital of Camp Zachary Taylor, Kentucky. Such a career did not appeal to me, so I returned to Honolulu in August, 1919 to engage in private practice. I had not hung out my shingle very long before I became extremely busy, especially at night. Scarcely a night passed without my having to dash out to some area where the less affluent resided. I concluded that establishing a practice was easier than I had anticipated. I soon discovered, however, this was a delusion. My flourishing practice resulted from all the deadbeats in town being referred by the other physicians.

Not being able by my flourishing practice alone to keep the wolf from the door, I succeeded in corraling a number of part-time jobs. Among others I became Board of Health Physician for the district of Koolaupoko, over the Pali in windward Oahu, and this entailed being a poi inspector. It paid $15 a month. The trouble was I could not find any poi to inspect and no one could tell me where to look. One day I was called to that area where a big luau (Hawaiian feast) was in progress, having been informed that someone needed a doctor. On arrival I found things in full swing, kalua pig was steaming among the rocks in the pit, Hawaiian maidens were doing the hula to the strum of ukuleles, and okolehao (native whiskey made from *ti* root) was flowing freely. I inquired about the patient I had been called to see, but no one seemed to know or care what had happened to him. Finally some old fellow said "Oh, he dead. We rolled him under the bench over there." I finally pulled the individual out from among the *ti* leaves and he sure was deader than a mackerel. Such a minor happening could not be allowed to interfere with a luau.

There was an old Chinese-Hawaiian in the little town of Kaneohe whose chief duty was keeper of the jail. On my twice-a-week trips to this area I kept seeing some old fellow sitting on the fence. I inquired around as to who this character might be but no one knew. One day I ran into the jailer and asked him who that fellow on the fence belonged to. "Oh," he said, "he belongs to me. This is my prisoner. He got lonesome sitting in the jail alone so I put him on the fence so he could watch the passers-by."

There was a receiving station in the outskirts of Honolulu where patients having leprosy were kept for varying periods of time before being transported to Kalaupapa, the leprosy colony on the island of Molokai. Sometimes these patients developed acute surgical lesions, and since they were not welcome at that time in existing hospitals in the community, an operating room was fitted up in the receiving station to take care of such emergencies. I was able to do cystoscopies, appendectomies, and an occasional acute gall bladder, adding further experience to my surgical knowledge and financial remuneration to my rather meager income.

While I have never been a believer in itinerant surgery, except under extenuating circumstances, I have performed many major operations in practically every hospital in these Islands that had an operating room worthy of the name. I must say some of them would never qualify for this distinction by modern standards. Shortly after interisland air travel became available in 1929, I got a call from one of the physicians on the island of Maui for whom I had great professional respect. He said that he had a patient in the hospital suffering from a bleeding gastric ulcer whom he thought it was inadvisable to move to Honolulu. Would I come over and operate? I tried to persuade him to get someone else but he said the family insisted that I come. I told him that I was extremely busy with a number of seriously ill in the hospital whom I did not like to leave and I was scheduled to operate early the next morning. However, after ascertaining when the next plane left for Maui, how long it would take to get to the hospital from the airport, approximate length of the operation, the time of departure of the last plane for Honolulu we figured I would be away from Honolulu but a few hours. When I arrived, the patient was under the anesthetic and he was still asleep when I left. Some years later an individual came to my office on what he said was a social call. "Well doctor," he said, "I just got curious to see what you look like and make your acquaintance." It turned out that he was the patient I had flown to Maui to operate on. "Well,"

I said, "my acquaintance with you in the past has been quite circumscribed also, and I too am glad to meet the rest of you since you recovered so well from the operation."

One day I got a call from a plantation physician several miles from Honolulu to see a patient injured when a truck crushed him against the wall of a building. From examination it was evident that he had an intra-abdominal injury and should be explored. This revealed that the head of the pancreas had been severed from its body and tail and most of the duodenum had been devitalized necessitating resection. In other words, a Whipple type of operation was in order. I realized that the spinal anesthetic which had been given would wear off before we could complete such an extensive operation, and we had no available anesthetist. There was a dentist in town who had had quite an extensive experience in administering anesthetics. He was sent for posthaste and was fortunately available. On his way out he was stopped by a police officer because of speeding. The officer, learning of the dentist's mission, said "follow me," and opened up his siren. They came roaring into the little village of Waipahu just in the nick of time, as the spinal anesthetic was beginning to wear off. The patient recovered after a rather stormy postoperative course and several years later was back at his old job of auto mechanic.

Before bringing this rather unorthodox type of paper to a conclusion I would like to recount one other episode to emphasize Dr. Straub's versatility. A young man in the preantibiotic era came under my care with a severe infection in the midline of his upper lip. Before getting the infection under control considerable loss of tissue occurred, which my endeavor as an amateur plastic surgeon to correct left much to be desired. One day Dr. Straub caught sight of this unhappy individual and concluded something had to be done to correct his unsightly appearance. He proceeded to do this by transplanting a flap of suprapubic tissue containing hair to the dorsum of the patient's hand, later transplanting it to his upper lip. This resulted in a very respectable handlebar mustache for which the patient was most appreciative. In later years this cosmetic accomplishment came to a rather sad ending since the advent of mini skirts necessitated keeping it closely cropped to prevent tickling his nose.

Before closing, I would just like to make a few other remarks about the Queen's Hospital, now called the Queen's Medical Center, with which I have been so intimately associated since my arrival in Hawaii. Over the years those of us interested in seeing better medicine and surgery practiced in this institution—and this can be said of all the other hospitals in Hawaii—have brought about changes so that the quality of patient care in our hospitals equals that of other similar institutions in continental United States. All of the surgeons now admitted to the staff of the Queen's Medical Center must either have their Boards or be Board eligible. I doubt that any other city in the United States has more visiting professors, outstanding practitioners, who spend from one to three months in our hospitals helping to keep our doctors abreast of modern developments. Queen's has two teams doing excellent work in open heart surgery, and kidney transplants have recently been carried out successfully in St. Francis Hospital.

With our new medical school, which we hope will shortly be a four-year institution, the future is bright for Hawaii to contribute more to the advancement of medicine in the future than it has in the past.

REFERENCES

1. Devine HB: Basic principles and supreme difficulties in gastric surgery, *Surg Gynec Obst* 47:239, 1928.
2. Devine HB: Gastric exclusion, *Surg Gynec Obst* 47:239, 1928.
3. Dragstedt LR, Owens, FMJr: Section of vagus nerves in treatment of duodenal ulcer, *Proc Soc Exp Biol Med* 53:152, 1943.
4. Mason EE, Ito C: Gastric bypass, *Ann Surg* 170:329, 1969.
5. Lewishon R, Feldman RH: Failure of gastroenterostomy to affect decisive reduction in gastric acidity, *Ann Surg* 82:925, 1925.
6. Raffensperger JA, Condon JB, Greengard J: Complications of gastric and duodenal ulcer in infancy and childhood, *Surg Gynec Obst* 123:1269, 1966.
7. Rydigier L: Pierwszy przy Padek gastro-enterostomy W. Obec Zwenzenia dwunaktiniey pro Wrzodzie Wyz drowienie' (Gastroenterostomy in stenosis of duodenum from duodenal ulcer with recovery, *Przegl lek Krakow* 23:249, 1884.
8. Swenson O: *Pediatric Surgery*, 2nd ed, Meredith Publishing Co., 1962.

Malaria--A Problem for Hawaii?

Malaria cannot become endemic in Hawaii, but it is being imported and even acquired here.

O'NEILL BARRETT, JR., COLONEL, MC, USA,
CARLTON G. REILEY, LT. COLONEL, MC, USA, *Honolulu*

Malaria has been seen with increasing frequency in Hawaii by both military and civilian physicians.

Epidemiological considerations make it likely that the disease will continue to be seen here for years to come. While introduced disease is unlikely, imported and induced disease, especially due to blood transfusion in the latter case, will occur.

A higher ratio of falciparum/vivax disease will be seen here in contrast to the fairly low incidence of falciparum disease on the mainland.

Comments on some clinical aspects of the disease as well as treatment and complications are presented.

ALTHOUGH MALARIA has always been a worldwide public health problem, eradication and control measures had been so effective in the United States that by 1959 the disease had, for practical purposes, been eradicated.[1] Only 50 cases were reported to the National Communicable Disease Center in that year.[2]

Subsequently, however, military involvement in Southeast Asia led to exposure of large numbers of troops to the disease with a progressive increase in numbers of clinical cases, especially in troops stationed in Vietnam.[3] The rapid turnover of these individuals and their return to the United States (approximately 500,000 in 1968) both to military bases and to civilian life, failure of prescribed prophylaxis programs,[4] and drug resistance in some cases have combined to make the malaria problem one of real concern to civilian as well as military physicians throughout the country. This article is intended as a review of some of the epidemiological and clinical features of malaria, especially as they apply to potential and real problems for Hawaii.

From the Department of Medicine, U.S. Army Tripler General Hospital, Honolulu, Hawaii.
Received for publication May 5, 1970.

EPIDEMIOLOGICAL ASPECTS

Although in 1957 malaria was described as the world's foremost medical problem,[5] impressive results had been realized from a global program of malaria eradication coordinated by the World Health Organization.[6] Complete eradication has been reported for such areas as Italy, Argentina, Chile, Venezuela, Panama Canal Zone, Puerto Rico, and Martinique.[5] Continued progress, however, has not occurred in all parts of the world, especially Southeast Asia where because of warfare and political and economic factors, eradication has been impeded or failed entirely.[7]

From a quantitative standpoint, the U.S. forces in Vietnam account for the majority of cases of malaria now being seen in the United States.[3]

Malaria became a serious public health problem for U.S. forces in Vietnam in 1966. In that year 6,000 cases were reported in servicemen there. During that same year there was a fivefold rise in the number of cases reported in the United States, a total of 764 being recorded, 620 in military personnel. With the continuing occurrence of disease in Vietnam,[3] there was also a rise of cases occurring in the United States, to 2,698 in 1967 and 2,487 in 1968. The vast majority of these cases (93%) occurred in persons who had served in Vietnam.[2]

However, the almost worldwide occurrence of disease and frequent travel to endemic areas by tourists, airline crews, seamen, and Peace Corps workers indicate that malaria can be,[7] and is,[2] brought into the United States from many malarious areas, not just from Southeast Asia.

Despite the concurrent increase in malaria cases in servicemen in Vietnam as well as in returnees from Vietnam to the United States, a striking difference between these two groups exists. Amongst

those cases which develop in servicemen while in Vietnam, 98 per cent are due to Plasmodium falciparum infection.[2] On the other hand, cases which occur in individuals who have returned to the United States are due to P. vivax infection in from 83 to 93 per cent of cases.[8-10]

This discrepancy is probably related to two factors concerning prophylaxis. First, while in Vietnam, all individuals supposedly received weekly chemoprophylaxis with a combined chloroquine-primaquine tablet which is effective in suppressing vivax malaria.[11] P. falciparum is relatively resistant to chloroquine suppression.[7, 12] Vivax cases occasionally occur, almost invariably related to poor chemoprophylaxis discipline.[13] Also, following return from Vietnam to the United States, each individual is instructed to take one of these chloroquine-primaquine tablets weekly for eight weeks. Such a program, if successfully accomplished, should be effective as "treatment for radical cure" for P. vivax infection, thus virtually eliminating cases of vivax disease from occurring in the United States.

Therefore, the observed high incidence of vivax malaria noted above suggests either that the drug program is not effective, or that enforcement of the chemoprophylaxis program is ineffective. There is no evidence at present to support the first possibility.[14, 15] On the other hand, we have recently presented data which demonstrate that 70 per cent of all individuals, following return to the United States from Vietnam, fail to complete the outlined course of therapy.[4] If these data are applied to the assumed troop turnover rate of 500,000 per year, then the potential number of malaria cases that might occur in the United States is indeed impressive.

Before attempting to apply some of this information to Hawaii specifically, several terms (to be used subsequently) should be clearly defined; they represent official terminology for malaria as recommended by the World Health Organization.[2] *Imported* malaria is that which is acquired outside of a specific area (in this case, outside the United States), even though symptoms subsequently develop while the individual is in the non-endemic area. *Introduced* malaria is that acquired by mosquito transmission from an imported case occurring within an area where malaria is not a regular occurrence. *Indigenous* malaria is that acquired by mosquito transmission is an area where malaria is a regular occurrence. *Induced* malaria is that which is acquired through artificial means, especially via blood transfusion or the use of common syringes.

Both on the mainland and in Hawaii, imported malaria is by far the most common form seen. However, several well documented instances of introduced malaria also have occurred on the mainland.[16, 17] Since the anopheline vector is present in most areas there and since a significant reservoir (due to imported cases) exists, the possibility of further introduced cases there must be considered, although widespread outbreaks are unlikely.[7, 11] In Hawaii, on the other hand, the absence of the anopheles vector eliminates the possibility of either introduced or indigenous malaria occurring here.[18]

Imported malaria is, however, and will continue to be, a practical problem for physicians in Hawaii. Since 1967, at Tripler Hospital, we have treated over 300 cases of malaria. Not surprisingly, about 40 per cent of these have been due to P. falciparum, most occurring in individuals on R&R (rest and recreation) and reflecting the high incidence of falciparum disease in Vietnam. A significant number, however, have occurred in individuals now in Hawaii either assigned to military bases here, or resident here after release from active duty. Many of these cases were originally seen by members of the civilian medical community. Because of the large numbers of permanent Hawaii residents who have been, and will be, assigned to Vietnam, a significant reservoir of potential malaria cases will exist for some time.

Fortunately, most cases of falciparum malaria occur within 30 days after departure from the endemic area, although there are several documented cases with prolonged incubation periods, the longest being 21 months.[2] In vivax disease, on the other hand, the usual incubation period is one to six months, and there are many well documented cases of vivax malaria developing as long as three to ten years following exposure.[2, 3, 4] Such delay will make recognition of disease more difficult.

While imported malaria will represent the bulk of cases seen, induced disease, especially that due to blood transfusion, must also be kept in mind. Since 1968, 12 cases of transfusion-induced disease have been reported in the United States, one of which terminated fatally. Of this group, six were due to P. falciparum, five to P. malariae, and one to P. vivax. Of especial interest is the fact that one of these cases occurred in a 15-year-old girl in Hawaii who had never traveled outside the Islands.

Theoretically, most cases of transfusion-induced disease would be prevented by routine blood banking restrictions, which preclude donation of blood by individuals for two years after either termination of treatment for disease or known exposure to malaria.[19] However, not all donors, particularly paid donors, provide honest information concerning previous exposure. Furthermore, based on the long incubation periods described above, the two-

year restriction will not exclude all possibly infected donors.[20] A practical indirect fluorescent antibody technique for detecting individuals with previous exposure to malaria is available but has not yet been used as a screening technique by most blood banks.[21]

CLINICAL ASPECTS

The typical clinical features of malaria are well described in standard texts and will not be repeated here. However, we would like to emphasize points which have been of particular value to us, especially some not stressed in recent writings on the subject. Finally, a few comments about current therapy and complications of the disease will also be made.

The classic picture of shaking chills and a high, spiking fever occurring at 48 or 72 hour intervals would alert most physicians to consider malaria in the differential diagnosis of febrile disease. However, this complete picture is present in only a minority of initial attacks of malaria seen in this country. Most commonly, malaria will present as a nondescript febrile disease almost always associated with shaking chills. The fever pattern of acute malaria in most nonimmune subjects becomes cyclic only after nearly a week of symptoms. Cyclic 48 hour fever spikes at the onset of symptoms usually implies relapse of a latent infection.

Despite the noncyclic pattern, the initial fever characteristics of acute malaria may provide several clues. The temperature nearly always spikes from normal to 103 or 104° F, or higher, and returns to normal within 24 hours. Only rarely will the temperature be sustained at a high level. In contrast to many other febrile diseases, the patient will be nearly asymptomatic when his temperature is normal. A temperature-pulse discrepancy is not uncommonly seen in malaria, though it is unusual in other febrile diseases seen within the United States. For example, a patient with malaria may have a pulse of 86/minute associated with a temperature of 104° F., when one would usually expect to observe a tachycardia of greater than 100/minute.

Several symptoms have been found particularly useful in considering malaria in a diagnostic evaluation. Headache, present in virtually all patients, is not usually severe or incapacitating. Nausea, vomiting, or diarrhea often occur, and may distract the physician from considering malaria as an etiology. Absence of certain symptoms of common febrile disease may likewise prove quite useful. Rhinorrhea, nasal congestion, sore throat, and productive cough are not features of malaria. Cough, if present, is nearly always nonproductive and occurs only during the febrile period.

Other than the presence of splenomegaly in about a third of patients, the physical examination is usually unremarkable in uncomplicated cases.

Routine laboratory studies are also generally unremarkable, but several changes occur frequently enough to be of value. The leukocyte count is usually normal or low; leukocytosis over 10,000/mm^3 is present in only 5% of cases. Two-thirds of cases have an initial white blood count of less than 8,000/mm^3 and approximately 30% have leukopenia. The differential frequently shows an increased number of juvenile neutrophils (band forms) and monocytes. The combination of an absolute increase in band forms in association with leukopenia strongly suggests malaria when it occurs in an appropriate clinical setting. Eosinophilia is not a feature of untreated malaria but may develop following therapy. Anemia depends on the duration and severity of disease and species, being more common in falciparum malaria.[22]

Diagnosis is established by demonstration of parasites in erythrocytes of the peripheral blood smear. Both thick and thin smear preparations should be examined. The former are of special value for screening purposes, but technically they are difficult to interpret. A diligent search of a thin smear preparation will almost invariably reveal parasites if they are present. Although more time-consuming, positive identification of the organisms is simpler with this technique and more reliable, especially for the inexpert observer. It should be stressed that while the Giemsa stain is recommended for evaluation of malaria, parasites are easily seen in erythrocytes on smears routinely prepared with the conventional Wright's stain.

With heavy parasitemia due to either P. vivax or P. falciparum, trophozoites, schizonts, and gametocytes may be seen. Even with light to moderate parasitemia in vivax disease, schizonts as well as trophozoites are seen. In comparable falciparum infestation, on the other hand, trophozoites may be the only forms seen.

The serious complications of malaria are limited to infection with the falciparum species. This parasite has the unique ability to parasitize all stages of red blood cells, whereas the more common vivax species infects only the youngest erythrocytes.

The renal, cerebral, or pulmonary complications of malaria are serious but uncommon, being present in less than one per cent of cases. They have highly variable features with ill-defined criteria[23] and establishing a definite diagnosis may be difficult.

Cerebral malaria, well known for many years, still remains difficult to classify or to specifically define in an individual case. Generally, one can state that any significant cerebral or central nervous system manifestation in a patient with

falciparum malaria could be part of the picture of cerebral malaria. From a practical point of view, however, the classic severe case, as seen in military hospitals in Vietnam, has been one of a comatose or confused, febrile patient with a clinical picture of malaria. Few localizing signs are seen, except for bilateral clonus and pathologic deep tendon reflexes. Nuchal rigidity may be present and the spinal fluid may be normal or show elevated pressure, mildly increased protein on occasion, or lymphocytosis.[24, 25]

Renal malaria may present as a picture of acute renal failure with red cells in the urine, or as the more classic picture of black-water fever with massive hemoglobinuria and azotemia, with or without oliguria. Careful observation of daily weight, fluid intake and output, BUN, and urinalysis for hemoglobin will help alert the clinician to the development of this complication.

Acute pulmonary edema, seen occasionally in falciparum malaria, is associated with a high mortality rate. The pathogenesis is not clearly related to either primary cardiac decompensation or fluid retention but rather seems due to functional pulmonary vascular abnormalities which occasionally progress to irreversible anatomic change.[26]

High degrees of falciparum parasitemia, especially above 10 per cent, are reportedly associated with a higher incidence of complications; however, complications have frequently occurred in patients where parasitemia was demonstrated only with much diligence and persistence. This is especially true for cerebral involvement.

TREATMENT

Treatment of malaria has become a more complex problem since the appearance of chloroquine-resistant strains of falciparum disease in Southeast Asia. Chloroquine remains the treatment of choice for the acute attack of infections due to P. vivax or P. malariae, and any cases of P. falciparum, except for those from Southeast Asia, where chloroquine-resistant strains are so common. Initial oral treatment with 1.0 gm (0.6 gm base) of chloroquine, followed by 0.5 gm (0.3 gm base) in six hours, then 0.5 gm daily for two days, will produce remission of all cases due to susceptible strains. Resistance of vivax to this medication has yet to be demonstrated. This drug, however, is not sufficient to cure the disease, since all strains, except falciparum, have a persistent exo-erythrocytic phase for which the 4-aminoquinolones (including chloroquine) are ineffective. Radical cure requires follow-up treatment with primaquine, 15 mg daily for 14 days. If an individual is on weekly chloroquine-primaquine prophylaxis, the same effect can be achieved by continuing this combined tablet once weekly for eight weeks.

Falciparum malaria in most areas of the world remains responsive to chloroquine in doses as mentioned above. Resistant strains of this species are so common in areas such as Vietnam that chloroquine is no longer used and a combined drug regimen has evolved, which is effective in over 97 per cent of cases.[27] This consists of the simultaneous oral administration of three drugs: pyrimethamine, 25 mg twice daily for three days; quinine, 650 mg every 8 hours for ten days; and either dapsone (DDS, Avlosulfon, diaminodiphenylsulfone), 25 mg daily for 28 days, or sulfisoxazole (Gantrisin), 0.5 gm four times a day for five days.

It used to be thought that black-water fever was caused by quinine. Although severe hemolysis due to quinine can rarely occur, black-water fever is a distinct complication of falciparum malaria whether or not quinine is used.

REFERENCES

1. Russell PF: *Malaria in preventive medicine, World War II,* Medical Department, US Army, in Communicable Diseases, Vol VI, edited by Hoff EC, US Government Printing Office, Washington, D.C.
2. *Malaria Surveillance,* 1968. Annual Report, National Communicable Disease Center, Atlanta, Ga.
3. Sheehy TW: Malaria in servicemen from Vietnam. *Ann Intern Med* 66:447, (Feb) 1967.
4. Barrett O'N, Skrzypek G, Datel W, et al: Malaria imported to the United States from Vietnam. *Amer J Trop Med* 18:495-499, (Feb) 1969.
5. Lisansky E: The eradication of malaria as an endemic disease in the United States. *Ann Intern Med* 48:428-438, (Feb) 1958.
6. *World Health Organization: Expert Committee on Malaria,* Sixth Report, Technical Report Series 123, 1957.
7. Blount RE: Malaria—a persistent threat. *Ann Intern Med* 70:127-129, (Jan) 1969.
8. National Communicable Disease Center, 1967. *Malaria Surveillance,* 1966 Annual Summary, US Dept of Health, Education and Welfare, Public Health Service.
9. Waterhouse BE, Riggenbach RD: Malaria. Potential importance to civilian physicians. *JAMA* 202:683-685, (Nov 20), 1967.
10. Martelo OJ, Smoller M, Saladin TA: Malaria in American soldiers. *Arch Intern Med* 123:383-387, (Apr) 1969.
11. Editorial. Malaria. *JAMA* 195:308-309, (Jan 24) 1966.
12. Tigertt WD: Present and potential malaria problem. *Milit Med* 131:853-856, (Sept) 1966.
13. Carbon MJ: Vivax malaria. *USARV Med Bulletin,* Jul-Aug 1967.
14. Inmon, MM, Gilliland, PF, Barry K: *Malaria Cures Highest with Combined Drugs.* Cited in *US Med* 3:14, 1967.
15. Barrett O'N: The problem of vivax malaria in Vietnam returnees. *Milit Med* 133:211-214, (Mar.) 1968.
16. Luby JP, Schultz MG, Nowosiwsky T, et al: Introduced malaria at Fort Benning, Georgia. *Amer J Trop Med & Hyg* 16:146-153, (Mar) 1967.
17. Lobel HO: *Introduced malaria case identified.* Antibiotic News 4:1, (Aug. 23) 1967.
18. Russell PF: World-wide malaria distribution, prevalence and control. *Amer J Trop Med & Hyg* 5:937-965, (Nov) 1956.
19. *Technical Methods and Procedures of the American Association of Blood Banks,* 4th ed., Amer Assn of Blood Banks, Chicago, 1966.
20. Chojnacki RE, Brazinsky JH, Barrett O'N: Transfusion-introduced falciparum malaria *New Eng J Med* 279:984-985, (Oct 31) 1968.
21. Leibovitz A, Freeborn RF, Lillie HJ, et al: The prevalence of malaria fluorescent antibodies in Vietnam returnees with no history of overt malaria. *Milit Med* 134:1344-1347, (Nov) 1969.
22. Riley CG, Barrett O'N: *The leukocyte response in malaria.* In preparation.
23. Sheehy TW, Reba RC: Complications of falciparum malaria and their treatment. *Ann Intern Med* 66:807-808, (Apr) 1967.
24. Daroff RB, Deller JJ, Kastl AJ, et al: Cerebral malaria. *JAMA* 202: 679-682, (Nov 20) 1967.
25. Carr A: *Cerebral malaria at the 8th Field Hospital.* Symposium on Falciparum Malaria, USAH, Fort Ord, California, (Nov 28) 1967.
26. Brooks MH, Kiel FW, Sheehy TW, et al: Acute pulmonary edema in falciparum malaria. *New Eng J Med* 279:732-737, (Oct 3) 1968.
27. Sheehy TW, Reba RC: Treatment of chloroquine-resistant Plasmodium falciparum infection in Vietnam. *Ann Intern Med* 66:616-622, (Mar) 1967.

Report from University of Hawaii Medical School

The Clinical Course of Survival in the Arctic

TERENCE A. ROGERS, Ph.D.,* *Honolulu*

Until recent advances in transportation technology, the only people encountering severe environments in remote parts of the world were natives (adapted to survive, by definition), or resourceful and experienced explorers, prospectors, etc. Now it is unfortunately likely that aircraft emergencies will continue occasionally to expose passengers and crews to very severe environments pending rescue. Furthermore, the very facility of access to remote regions by light aircraft encourages hunting, for example, by parties whose training and equipment are thoroughly inadequate for survival in emergencies.

"Death from exposure" is a common enough term, but one which has not been subjected to much investigation. Leaving aside the obvious problems of dehydration in a desert or life-raft situation, we can recognize that hypothermia is a salient characteristic of death from exposure. It is not clear in all instances, however, whether hypothermia is the primary problem or whether it follows some other breakdown of the body's homeostatic mechanisms. The most obvious examples of hypothermic death are those from immersion in very cold water, exposure to the winter arctic with inadequate clothing, or prolonged exposure to rain and wind even in temperatures above freezing. In the latter instance, however, there is good evidence that profound fatigue is a precursor to losing the capacity to maintain body temperature.[1]

In arctic emergency situations men have been found dead after only a few days, when their standard of clothing would be expected to have kept them warm indefinitely. This, coupled with the old idea that men in the arctic need a very large food intake, is probably the origin of the tenacious myth that men in the arctic can starve to death in only a few days. The studies described in this paper are part of a research program directed at the "clinical course" of arctic survival situations and the nutritional requirements to meet the stresses.

Following the subjective experience of two three-day simulated arctic survival situations with minimal rations, we concluded that the malaise, discomfort, and anxiety were out of all proportion to the cold actually experienced and to the biochemical changes consequent to only three-days of undernutrition. The thirst experienced immediately after return to normal conditions had been noted anecdotally by other observers, and had been attributed to dehydration due to the high rate of water loss in expired air. Buck[2] has shown this water loss to be as high as one liter per day

* Department of Physiology, University of Hawaii School of Medicine.



FIG. 1.—*Measuring the oxygen consumption rate in an arctic survival situation.*

in an active man in the arctic. The absolute humidity of inspired air at –40°C is vanishingly small, and the expired air is saturated at about 32°C under these conditions.

Our experiments comprised simulations of survival experiences conducted with as much verisimilitude as permitted by the necessary experimental procedures, reasonable safety, and the dictates of common humanity. Nevertheless, it should be acknowledged at the outset that although the subjects had authentic environmental and nutritional stresses, they were completely aware of the simulated nature of their isolation and had none of the crushing anxiety that would affect a real survivor. In some ways, however, this was originally regarded as an experimental advantage, since we were therefore able to observe the physiological impact of the physical components (cold, hunger, etc.) without the overlay of the physiological correlates of anxiety. Even this was not clear-cut, however, because some of our subjects became surprisingly anxious, even to the extent of believing they would be abandoned by their colleagues, a thoroughly unrealistic fear.

METHODS

The recommended policy for survivors of aircraft accidents in the arctic is to stay in one place and await rescue, since they seldom have the equipment and experience necessary to walk out to civilization. Accordingly, in two major experiments a total of 12 physiologists and medical students were set out individually in simulated survival situations in central Alaska during the month of February. Temperatures ranged from –25 to –40°C with no wind (–40°C is the same as –40°F). The subjects were identically dressed and equipped as if they had ejected from small aircraft, and had parachutes and survival kits, from which the food had been removed. They built individual shelters from their parachutes and willow sticks on a frozen river, and spent five days without food, but with water ad libitum. During these five days numerous observations were made, including the semi-continuous measurement of oxygen consumption (Fig. 1), 12-hour urine collections, daily determinations of body weight, ECG, heart rate, and blood pressure, and the drawing of a blood sample. The latter pro-

cedures were conducted in a heated hut near the experimental site.

Prior to the experiments the subjects consumed a standard diet (the same items for each man each day) yielding 2500 kcals/day and of known electrolyte content; they resumed this diet after the field exposure phase.

In some follow-up studies, large groups of volunteer soldiers with close supervision served as subjects in generally less rigorous experiments designed to elucidate specific points arising from the first two experiments.

In all experiments, urine and blood samples were frozen for subsequent analysis. Plasma and urine cations were determined by conventional flame photometric methods, urine ketones by the method of Thin and Robertson,[3] and plasma glucose using an anthrone method.[4] Oxygen consumption determinations were made using the Wolff integrating motor pneumotachograph.[5] This measures the volume of expired air electronically and collects a small integrated sample of mixed expired air. These gas samples were analyzed for O_2 and CO_2 in the field laboratory, using a Scholander micro gas analyzer. From these data, oxygen consumption, carbon dioxide production and the respiratory quotient, could be calculated.

RESULTS

The first two experiments illustrated the "clinical course" of a starving survival situation under these conditions. The immediately obvious effects were rapid and severe weight loss, apathy, and malaise. The mean weight loss amounted to 8% of initial body weight, but 5% of this was recovered during the five-day follow-up period on the standard ration, which was demonstrably adequate only for maintenance. Plasma glucose fell predictably to 70 mg% in 48 hours and then rose gradually to 86 mg% by the fifth day of starvation. Mean urine ketone body excretion reached 5 grams per day (as acetone) by the third day, and the total for the five-day starvation period was 15 grams. Ketonuria disappeared immediately upon refeeding.

Urine sodium losses amounted to a mean total of 350 mEq during the five days of exposure, and this was exactly matched by the retention of dietary sodium during the five days of controlled refeeding. Since plasma sodium concentrations were stable throughout, the loss of 350 mEq of sodium must be associated with a 2.5-L contraction of extracellular fluid volume. This is consistent with the severe weight loss, and with the immediate recovery of part of that weight loss with the sodium retention in the refeeding phase. Further evidence of an isotonic contraction of extracellular fluid volume is provided by a rise of mean hematocrit from 47% to 52% during exposure, a rise in the mean plasma refractive index from 1.3490 to 1.3507, pronounced tachycardia (95 upon walking), and a narrowing of the pulse pressure. Except for the tachycardia there were no EKG anomalies.

The oxygen consumption measurements indicated a mean total caloric cost of 20,000 kcals for the five-day period, with 4500 kcals/day for the first two days when the subjects were extremely active building shelters, etc. The daily cost tapered off thereafter, which was consistent with the diminished voluntary activity of the men.

DISCUSSION

Our most interesting findings are that the severe weight loss in this kind of environmental stress is largely due to an isotonic contraction of extracellular fluid consequent to renal sodium losses. The actual caloric expenditures are not extreme, and relate more to the intense physical activity involved in coping with the arctic environment than with the demand for heat production *per se*. Our subjects were frequently extremely cold at night, but even on a night when five out of six incurred superficial cold injury to their feet, the mean caloric cost for the 24-hour period was only 3500 kcal.

Urine nitrogen losses during exposure indicate a loss of 390 grams of protein, which would amount to about 1.5 kg of actual tissue. This would presumably be rapidly replenished during refeeding, and certainly this 1.5 kg plus the 2.5 L of extracellular fluid loss associated with a 350 mEq loss of sodium completely accounts for that part of the original weight loss recovered during the refeeding period.

The 3% of initial body weight still not recovered after refeeding must be all fat loss, since liver and muscle glycogen levels and the labile protein stores would have been replenished. The caloric yield of this utilized body substance was 6700 kcal/kg, which is consistent with its being adipose tissue. (Pure fat yields 9000 kcal/kg).

We cannot consider the loss of two kilograms of fat and a few hundred grams of protein as serious threats to life, and yet five days of this kind of depletion has proved fatal in real-life survival situations. Our attention is drawn to cardiovascular repercussions of the contraction of extracellular fluid and the effects of hypoglycemia and ketosis. These might be expected to contribute to the apathy and malaise universally encountered under these conditions, and our subjects reported orthostatic intolerance and distress upon exercising. We could expect that these factors would diminish the motivation of a survivor to take

TABLE 1.—*Typical clinical pattern presented on 3rd day of a simulated arctic survival situation.*

Well nourished male, aged 24	
Temperature:	37°C
Resting heart rate:	95
Blood pressure:	110/95*
Hematocrit:	52%
Plasma glucose:	70 mg%
Plasma total CO_2	19 mEq/L
Plasma Na:	142 mEq/L
Plasma K:	4.2 mEq/L
Pronounced ketonuria	

* Dizzy upon standing from recumbent position.

energetic steps to provide himself with adequate shelter and to get generally organized. Further, Engel[6] has listed several physiological states which contribute to the likelihood of syncope. These are: (1) Reduction in blood volume. (2) Hypoglycemia. (3) Cold exposure. (4) Painful stimuli of the upper g-i tract. (5) Anxiety. All are present in an arctic survivor, and the dangers of syncope for a solitary man in a bitterly cold environment need no elaboration. Furthermore, the reduction in blood volume could be expected to increase susceptibility to peripheral cold injury, which again, would diminish a man's ability to cope with a survival situation.

Table 1 summarizes the typical clinical pattern seen in a man undergoing this kind of arctic survival situation. He is clearly a candidate for the administration of sodium chloride (or bicarbonate, or both) and glucose. It occurred to us then that arctic survival rations should be designed to minimize the symptoms as much as possible, bearing in mind that a caloric deficit is inevitable. They should be based on the principles of good fluid and electrolyte therapy rather than the conventional rules of balanced nutrition.

We then conducted a series of experiments testing the value of sodium and glucose supplementation in arctic survival. In brief, we found that 100 mEq/day of sodium will prevent the isotonic contraction of extracellular fluid volume. This supplement can advantageously be presented as sodium bicarbonate tablets, since they help diminish the systemic acidosis and the gastric distress of fasting. We also found that this supplement should be tapered off over a five-day period; otherwise, the extracellular fluid contraction occurs with even more calamitous effect if the supplement is terminated suddenly while the fasting survival situation prevails.

We also found that 500 kcal/day as sucrose was enough to suppress all ketonuria. The men subjectively felt better, especially those also receiving the sodium supplement, but they actually complained more of hunger than those fasting completely. This is perhaps attributable to the anorexic properties of the ketone bodies.

Men fed on the USAF survival ration based on pemmican bars (at the rate of 500 kcal/day) had a similar physiological course to that described for complete fasting. The pemmican bar is made of dried powdered meat combined with fat, so that the fat provides 50% of the calories. This is essentially the same biochemical source of calories as in the fasting man, and it is not unexpected that the metabolic consequences are similar.

Accordingly, it is recommended that an arctic survival ration should comprise sodium bicarbonate tablets and hard candy.

REFERENCES

1. Pugh LGCE: Deaths from exposure on Four Inns Walking Competition. *Lancet* 1, 1210, 1964.
2. Buck Alan C: Water Content of expired air in man. Thesis, University of Hawaii, 1967.
3. Thin C and Robertson A: The estimation of acetone bodies *Biochem J* 51:218, 1952.
4. Craig AB Jr and Waterhouse C: The volume distribution of high molecular weight dextran and its relation to plasma volume in man. *J. Lab, Clin Md.* 49:165, 1957.
5. Rogers TA, Setliff JA and Klopping JC: Energy cost, fluid and electrolyte balance in subarctic survival situations. *J Apl Physiol* 19, 1, 1964.
6. Engel AL: *Fainting*. Thomas, 1950.

The way to know that something might happen is to know that once, somewhere, it did *happen. The way to know that fluoridated drinking water might be harmful would be to know that somewhere, once upon a time, it* was *harmful to someone. Dr. Frederick Exner of Seattle had a couple of weeks in a Federal court in which to prove this—and he couldn't do it. The reason he couldn't do it is because it hasn't ever happened—not once, so far as available evidence goes, which is pretty damn far, after some 30 years. Fluoride poisoning has occurred from naturally fluoridated water—but never from artificially fluoridated. All Honolulu's Pure Water Association is really accomplishing is continuing malnutrition for Honolulu's children, who are compelled to drink fluoride-deficient water and can only build soft, vulnerable teeth as a result.*



CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 312, Camden, New Jersey 08101.

There's a soup for almost every patient and diet ...for every meal and, it's made by Campbell



The President's Page

Many activities are keeping your Association's officers and staff busy. Two full days of hearings were held on Mr. Hasegawa's proposal for changes in the Workmen's Compensation fee schedule. Except for one witness, everyone who testified favored "usual and customary." This included representatives of labor, management, insurors, and the HMSA, as well as doctors. We are awaiting word of Mr. Hasegawa's findings.

Medical liability insurance continues to be a problem. We know of two orthopedic surgeons who wanted to practice in Hilo, who decided against it when they learned what they would have to pay for insurance. Insurance Rating Bureau figures for the five classes of insurance were doubled on November 12, 1970, and are now $431.00 for Class I insurance and $2722.00 if you are in Class V. Hawaiian Insurance and Guaranty Company is continuing to accept physicians at these rates plus surcharges based on years of practice, age, claims history, and incorporation. We hope the allowed rate increases will attract other insurors to write liability in Hawaii. We have scheduled discussions with one possible insuror this week.

On December 1, Dean O'Rourke of the School of Public Health presented his proposal for a Hawaii Research and Development Program. You will hear more about this. Dean O'Rourke indicated his willingness to present this to the other counties if they request it. The relationship of this to RMP, Community Health Planning, and the HMA's study of quality of care is not clear. I feel we are being put in the impossible position of being asked to approve something without being told its ramifications. I have been directed by the Council to ask Dr. Sanazaro to meet with us.

Hawaii, I believe, is in the forefront of the nation in developing and using new methods of delivering health care. If these can be applied elsewhere, fine; but to suddenly suggest all these methods should be reviewed with the object of changing them and setting up a new super brain trust to run the whole system suggests to me that someone not now involved has some kind of superior intelligence, which I do not think exists.

John J. Lowrey

HAWAII MEDICAL JOURNAL

Editorials

Health Care Delivery in Hawaii

Edward O'Rourke, Dean of the School (it is still called that) of Public Health of the University of Hawaii, is calling for a two-year study of health care in Hawaii. He wishes to determine the strengths and weaknesses of the present delivery system in the greatest possible detail and see whether it should be modified, and if so, how.

On its face this does not seem unreasonable. If there are shortcomings in our system, we should know about them so that they can be corrected. Making the same mistakes over and over does not lead to learning by experience. The fact that under the sweeping proposals of the study our medical profession would become rather like guinea pigs for a couple of years is a little distasteful, but not a strong argument against such a study.

But a deeper look discloses other aspects of this proposal. It becomes obvious that Dean O'Rourke already knows what the answer will be. It will be that the present system is basically wrong and needs to be replaced with a new system of his design. One can be sure, painfully sure, that all the evidence will be gathered, and evaluated, with this goal clearly in mind. It will be like asking the wolf to explore methods of getting Little Red Riding Hood safely to her grandmother's house.

Concurrently with the proposed two-year fact-finding period, Dean O'Rourke proposes the establishment of a corporate fiscal organization capable of handling the financial problems incident to a total governmental health care system, so that it will be operative by the time the study is concluded.

The whole proposal is like the famous trial in Alice in Wonderland: "Sentence first," said the King. "Verdict afterward."

Under the proposed ground rules and with its present sponsorship, the medical profession of Hawaii should decline to have anything to do with the project.

We do not deny the potential usefulness of such a study, if the medical profession can be fully involved in its planning and execution instead of being merely the object of it. Under such ground rules we would advocate an attitude of cooperation.

National Health Insurance–Inevitable?

The prospect of a National Health Insurance plan in the United States looms larger.[1] Presently, at least five health insurance bills are before Congress (Reuther Plan, S.4297; Javits Bill, S.3711; Griffiths Bill, H.R. 17806; Dingell Bill, H.R. 24; and Medicredit, H.R. 18567).[3]

Varied pressures abound to get an additional health scheme adopted in the near future. Many congressmen and some of organized labor back the Reuther Bill. This bill establishes fee schedules and regional budgets. The Javits Bill has considerable support from "middle-of-the-roaders." The AFL and CIO support the Griffiths Bill, whose cost and impact on doctors would be heavy, since it proposes a national prepayment plan of medical care set up under contract with the Federal Government. The Dingell Bill has been tossed around since 1943. Its effect on physicians would be slight, but it has practically no chance of passage.

Medicredit is a health insurance plan propounded by the AMA. Its cost would be less than that of either the Reuther or Javits Bills, and its impact on doctors would be small, since the present health care delivery system would be only subsidized, not changed. State medical societies would participate in the establishment of "peer review" systems, charges, and utilization pro-

cedures. Congressional support for this bill is gaining, but is still behind that for some of the others.

At a time when five possible solutions to health care woes of the USA are being considered, news from the other side of the Atlantic and from Quebec Province in Canada is less than encouraging. In Britain, physicians constantly criticize the NHS, with their complaints centering on long hours and low pay.[6] A "brain drain" is in evidence. The NHS is being urged to turn to out-of-pocket payments of insurance to supplement Treasury funding. This is a reversal of previous policy and a trend towards the present system in the U.S.[2]

In Quebec, on the other hand, physicians were recently outraged by a newly proposed compulsory medical care program.[5] This program was to be supported by tax funds. No physician would have had the right to remain outside of, or leave, the program, for any reason, and also a basic unilaterally set fee schedule would have begun at 65% of present charges. This program would have thus effectively outlawed all private practice in Quebec! The law was repealed December 9.

Some say, "It is a question, not of whether we will have National Health Insurance in the United States, but of when." If this is the case—and most likely it is—can we, as physicians, learn from the errors of others? There are things wrong with our system, both in delivery and care. We don't have enough doctors or paramedical personnel. Many of our health care facilities warrant improvement, and we need some new ones. Utilization and "peer review" practices require additional supervision and control.

In an attempt to solve our problems in health care, let us first recognize that they exist. As in basic management, we must first identify, then accurately analyze the problems; translate them into goals or objectives; and set a path by which these goals may be achieved.[4] The time is ripe for us to end our complacency, recognize our faults, and act accordingly. If we don't, someone else will!

MERYL H. HABER, M.D.

REFERENCES

1. Carlova J: National health insurance: Three lessons from abroad. *Med Econ*, pp 96-110 (Sept 28) 1970.
2. Editorial, Atlantic Trends. *Lancet* 2:302, 1970.
3. National Health Insurance: Five contenders compared. *Med Econ*, pp 284-289 (Oct 26) 1970.
4. Novit MS: *Management by Objectives: Basic Manual*. Graduate School of Business, Indiana University, Bloomington. 1970.
5. Quebec doctors face shutdown. *Bull Amer Coll Rad* 26:4, 1970.
6. Ulman N: *Doctors' Dilemma, British Physicians Fault National Health Plan but Say Sick Benefit*. Wall St J, Vol 3, #80, 1970. p 1.

Nutritional Emergency

Whether you're a child doomed to lose teeth, or an adult who has lost his and now stands to lose only money, the prevention of tooth decay by fluoridation of Honolulu's water supply is a matter of real urgency to you.

Tooth decay — preventable tooth decay — damages or destroys half the teeth of 98.6% of Hawaii's children by age 16. And two out of three of them get inadequate or no dental care. No other state in America has so bad a record.

Even if the victims could afford dental care, and many cannot, dentists are just too busy. The increasing demand has overtaken their ability to deliver dental care.

Nationally, fluoridation is doing a great job, and it's getting better all the time. Over 88,000,000 people, some 56% of the American population, in 7,400 communities, are drinking fluoridated water and receiving the benefits of its protection. Most recent additions to the list are Long Beach, Huntington Beach, Fountain Valley, and Beverly Hills.

Fluoridation is now mandatory in seven states: Massachusetts, Delaware, Ohio, South Dakota, Minnesota, Illinois, and Michigan.

Hawaii's military bases have had fluoridation since 1956. One civilian community, Maunaloa, Molokai, has had it by their own request since 1961. Not a single episode of "poisoning" has occurred. Nine-year-olds in Maunaloa already show the expected 60% reduction in dental caries; in their front teeth, where it shows, the reduction is virtually 100%.

Few adults are still affected by the absurd and totally false fright and hate propaganda against fluoridation. Some are still deluded by the argument that this is compulsory medication.

It isn't medication at all. It's nutrition. Fluoride is essential to the formation of hard, healthy, decay-resistant tooth enamel, and the only effective way to get it is in drinking water—Nature's way of supplying it.

What IS compulsory is the malnutrition now being inflicted on our growing children—over 30,000 of them every year!—by supplying them with nothing but fluoride-deficient water to drink. Hawaii's water is good, but it's so pure it's deficient in this important mineral ingredient. It needs upgrading.

If you have any compassion for our children, whose teeth are the worst in our nation; if you have any concern for your own pocketbook; then tell your City Council representatives that you want them to order the Board of Water Supply to institute fluoridation now!

Slants and Angles

HAWAII MEDICAL JOURNAL

Polluted Waters

There have been much anguish and lament recently about the health hazards of swimming in the tainted waters of Keehi Lagoon and Waikiki beach. Most noise, as expected, came from the vested financial interests who have turned Waikiki into a concrete jungle which must, at all costs, be kept full of free-spending tourists.

Let them take heart—for, after all, adversity is just opportunity in disguise. Long-range epidemiologic studies indicate that exposure to filth, flies, and feces during childhood results in relative immunity to poliomyelitis, infectious hepatitis, and multiple sclerosis in later life.

Perhaps the Hawaii Visitors Bureau should mount a nation-wide campaign with this idea in mind, using such slogans as—"Safeguard your future health: spend a vacation in the polluted waters of Waikiki." "Filthy conditions guaranteed." "Coliform counts constantly kept at hazardous levels by certified inspectors." "Special water carnivals during Kona weather."

Sweeney Todd Strikes Again

Sweeney Todd, the demon barber of Fleet Street, was one of the more colorful characters of 19th century London. His special tour de force was using his razor to slash the throats of those unfortunates who sought his tonsorial talents.

Perhaps his modern day successors have inherited some of these health-destroying skills. Dr. J. Kohn writes in *Lancet,* October 17, 1970:

"In the copious literature on the etiology and epidemiology of hepatitis, and the correspondence in your journal, evidence has been accumulating that serum hepatitis can be transmitted by means other than the classical blood-transfusion and the syringe. A variety of routes of transmission have been implicated. I wonder whether an obvious epidemiological hazard should not be seriously considered. I would like to suggest that dry shaving of the skin on the back of the neck and around the ears following a hair-cut, usually performed by means of a razor, may play an important role in the transmission of serum hepatitis. This procedure almost inevitably produces minor superficial skin abrasions and quite often minute cuts. Stropping of the razor is an added risk in that the strop can serve as a reservoir of infection. Most men will recollect the smarting sensation at the back of their necks. I very much doubt whether the precautions taken between customers, if any, and the methods employed for 'sterilization' or disinfection of the razors, could even remotely be regarded as 'serum hepatitis proof.' A perfunctory dip of the razor, or even short immersion in a disinfectant solution, can hardly be expected to destroy a notoriously resistant virus."

Maybe those long-haired hippies are smarter than we think!

New Use for Mongoose

The wild Hawaiian mongoose is a familiar sight scuttling along the roadsides of rural Oahu. Looking like an overgrown rat, this fierce predator is a popular house pet in India, where it is used to kill snakes and small vermin. There being no snakes in Hawaii, this useful animal has until recently, been regarded as something of a nuisance and has become the butt of occasional Hawaiian jokes. Example: "What is the plural of mongoose?" Answer—"Plenty mongoose!"

Now this is changing, thanks to the needs of medical research and more particularly of Honolulu pathologist Dr. G. N. Stemmerman. Apparently, the wild mongoose is peculiarly prone to develop spontaneous lipid pneumonia and pulmonary adenomatosis. The reason for this is not understood and the problem is currently being investigated by Dr. Stemmerman who hopes that this work may shed some light on similar conditions affecting humans.

Fitness and Fatness

"Inside every fat person, there is a thin person struggling to get out." A familiar cliché, and possibly a true one. Being considerably overweight, this columnist feels close to the problem, and has read with concern the masses of statistics relating obesity to coronary artery disease, stroke, diabetes, and premature atherosclerosis. One can, I suppose, extract a modicum of comfort from knowing that being overweight enabled one's corpulent ancestors to survive pestilence and famine during more trying times.

continued page 60

Hawaii Academy of General Practice

. . . Every Doctor's Office

We are being befuddled and confused by all this talk about comprehensive medical care.

If you take an individual patient as an example, the matter of concern would be whether the state of his health was being monitored adequately.

First and foremost, that would be HIS concern. If the do-gooders of dreamworld think our society should throw itself into a health scheme in which the individual citizen is not only led to the water but also forced to drink it, then beware! We would truly be in for a police state, in comparison to which the USSR would be a land of freedom and liberty.

However, our society does admit a social consciousness. Government should indeed concern itself, not only with the adequacy and availability of protection to health via good housing, nutrition, and sanitation, but also via general education and particularly medical education. None of these,except perhaps the last—since we physicians would know best what to teach the lay public of matters medical—need come under the aegis of the medical profession. If a man or child be well fed, and properly housed; if good sanitation preserves his health; if his living conditions make for peace of mind; then surely that person has a satisfactory start toward good health. The economics of his situation will shape in large measure the well-being of his body and mind. If, in addition, he is taught how to preserve his own health, and takes heed to what he is taught, the much over-stated "problem" of health care will be minimized.

Simple, so far, is it not? Then why all this obfuscation about comprehensive health care?

The answer may be brought into better focus if we admit to a reasonable separation of responsibilities: that of the individual to look after himself, as against that of his physician to perform a comprehensive evaluation of his physical and mental condition, make a diagnosis, and prescribe proper treatment or prevention of deterioration.

We have already outlined the responsibility of the individual to look after himself (or his family). We have pointed out acceptable social consciousness toward the obligations of society in matters of housing, feeding, and sanitation, and in education—all of these being directed toward assisting the individual in assuming his burden of self-care.

Now, what of the role of his physician?

Every physician has an obligation—his oath of Hippocrates—toward his patient. This is to make him well, if he is sick, and to keep him well, if possible.

I consider a solo general practitioner practicing in his own little cubbyhole out in the boondocks a provider of comprehensive health care if: (a) he cares adequately for his patient or his family in each instance of a medical crisis; (b) he instructs the young mother in good prenatal care and then later in child-rearing, advising as needed on matters of preventicare; (c) he seizes every opportunity—every time father comes in with a minor flu, for example—to do a thorough evaluation of the state of his general health and, particularly, to take time to educate his patient in health care with an eye to his future well-being; and, (d) he makes himself locally available for medical counseling to individuals or groups.

So-called, new-language "comprehensive health care" does NOT necessarily mean care under one roof or one health plan, as the HEW experts would have us believe, is best. I say: does NOT in the sense that an individual patient can very well lose all identity, if not his mental health, just as easily if the "one roof" or the "one plan" treats him as an un-person—a computer number—and the one-to-one relationship is totally lost.

Unfortunately for us and for our patients (the latter should come first, always!), there are too many solo physicians who treat the patient casually rather than comprehensively. There are too many "solo-minded" physicians in large groups who practice similarly. There are too many specialists who focus on just a part of the body, to the exclusion of the whole patient, or his family, or his community. There are too many of us physicians who abrogate our over-all responsibility for the welfare of the whole patient, including his pocketbook, by "referring out" his various parts. Not only in medicine does over-specialization lead to dehumanization.

Let the arbiters of social consciousness concern themselves with healthful living! We physicians can, and need to, provide comprehensive health care right in our own offices, be they solo, in a group, or in an institution.

J. I. Frederick Reppun, M.D.

Inside HMA

HAWAII MEDICAL JOURNAL

Telling It Like It Is

This issue, I plan to take to task those committee chairmen who do not bother to make reports, hoping that the newspapers do not find this interesting enough to put in the daily again.

It is intended that my column be based on the committee reports received from each committee chairman by HMA. I have available for this issue's review a total of 13 reports, from 11 committees. This happens to be about the largest number I have had, but woefully inadequate. When I ask the girls at the HMA office if that is really all the committee meetings there have been in two months, they say, no, such and such a committee met, but the chairman hasn't signed and returned the report. The girls do all the work, and all the chairman has to do is read it quickly, make corrections if any are needed (which is rare), and sign it and have his secretary return it. Often, this doesn't happen. And if there is never a report to the Council, or the membership, the committee wasted its time meeting.

If I were a chairman, and too busy to read and sign the report, I would either resign, or assign the job of handling the report to some member of the committee. If all the committee members feel they are too busy to take care of this vital detail, then why not fold the committee up? Otherwise, you are just spinning wheels to no useful purpose.

If your committee is meeting, but you are not reading about it in this column, I urge you to ask your chairman whether he is finishing up the reports and submitting them promptly.

Health Manpower is working hard on the new proposal to license physicians' assistants. The National Academy of Science has recommended defining three types: Type A, with considerable knowledge, able to interpret findings on the basis of general medical knowledge and exercise a degree of independent judgment; Type B, possessing skill in one clinical specialty, or in certain procedures, beyond that possessed in that special field by a Type A assistant; and Type C, capable of performing a wide variety of medical tasks, but not able to exercise the independent synthesis and judgment of Type A. They are sending out questionnaires to determine how you might use the same, and to find out to what extent you are willing to assist in the training program.

No doubt because I shot off my mouth a couple of issues ago, **News Media** has dumped the rewriting of a new code of cooperation, and physicians' publicity code, in my lap. Some progress is being made, about which you will hear more later. The committee members recognize that a good public image for any organization depends on the frequent appearance in print, on TV, and otherwise in the public eye, of the organization, and of its members, in connection with worthwhile and interesting activities. If we want to improve our image, we must start getting more doctors' names and pictures in the papers, etc., which means we must overcome the general feeling that any publicity connected with doctors is bad or is advertising.

Careers is working with the newly formed Health Careers Council to plan a better and expanded Health Careers program.

Communicable Disease has been working with the strep epidemic at Kawananakoa school.

After two years of inactivity, the **Filipino Speaker's Bureau** has acted to establish a group of Filipino speakers for TV and radio on medical subjects.

Environmental Health, rolling with the new interest in ecology, is discussing stands HMA should take on various aspects. Lots of discussion, but few decisions evident. How about more decisions, men? The time for us to take firm stands is NOW.

TV-Radio continues its excellent work of planning the Wednesday evening programs. I hope you watch them often.

Public Relations is studying the questionnaires you all received (and half of you returned) on your thoughts on public opinion. A public relations counselor is still not selected, because Tom Thorson reports that HMA is over-budgeted $16,000 for the current year, and PR is having to take the brunt of the cut. Seems to me a pretty poor place to make such cuts, our public relations being as sick as they are. Like the man who stays home from work for weeks on end because he feels too poor to go to the doctor.

Bureau of Research and Planning is trying to find money for seminars on utilization of the Beverly Payne report at $1,000 per seminar.

JOHN BROWN, M.D.

University of Hawaii

The medical students of the University of Hawaii enjoyed a unique clinical privilege early in December when they heard several lectures by visiting cardiologist **Professor Emeritus George C. Griffith** of the University of Southern California.

Among his presentations was the demonstration of a clinical work-up of a cardiac patient. This began with the establishment of rapport between doctor and patient. A complete history followed. Finally he went through the steps of a careful physical examination. He emphasized scrutiny of the peripheral vascular system in evaluation of the heart and its function, a point made by his great teacher, Sir Thomas Lewis. In auscultation of the heart, he listened to the heart sounds initially, without any regard for murmurs. When he had described the heart sounds, he then went back and listened for murmurs. The case, one of rheumatic heart disease with both aortic and mitral valve involvement, lent itself particularly well to study, and the students were all able to hear the heart sounds and murmurs by means of an amplification system. On the examination of the spleen, Dr. Griffith referred to the method of the surgeon, John C. Da Costa, another of his early teachers.

Dr. Griffith, age 72, a contemporary of such cardiologists as Paul Dudley White and Samuel Levine, had the advantage of studying with such men as Lewis of England and Wenckebach of Vienna. And yet he is very forward-looking in his approach to the treatment of coronary artery disease, recommending, for patients with angina, a ciné study, and if arterial obstruction is demonstrated, reversed-vein by-pass grafts from the aorta to coronary arteries. For ischaemic cardiac muscle that is the source of arrhythmias or prolonged shock, he recommends putting the patient on cardiopulmonary pump and excising the ischaemic zone (infarctectomy).

Just two years ago, Dr. Griffith, as visiting professor here, gave a lecture on what to do for a patient with an acute myocardial infarction. That very night, in his Waikiki hotel, he suffered an infarction himself. Fortunately, the hotel physician who was called to take care of him had heard the morning lecture, and carried out the prescribed initial treatment successfully. After a month in the Coronary Care Unit of the Queen's Medical Center, Dr. Griffith returned to Los Angeles where he lay abed for 8 months, much of the time in pulmonary edema. Finally, surgeons excised a ventricular aneurysm from his heart, and closed the defect by apposing healthy myocardial margins, following which he has done very well.

Sensing an obligation to finish the series of lectures here that was interrupted two years ago by his illness, he requested to return and resume it. Resume it he did, with great vision and clarity. The medical school and the medical community at large were indeed fortunate to meet him and hear him.

C. S. Judd, Jr., M.D.
P. W. Hong, M.D.

X-ray View Box

HAWAII MEDICAL JOURNAL

• An 18-year-old boy was working with a paint spray gun when "something flew back and hit my hand!"

• Examination revealed a diffusely swollen hand with a small puncture wound of the second interdigital web.

• There was only minimal pain and there was no impairment of function or of sensation.



Examination of the x-rays showed no bony abnormality and with radiolucent separation of the soft-tissues by air (best seen in the lateral projection with soft-tissue technique). The small puncture wound was cleansed, a tetanus booster was given, and healing was rapid and complete.

Similar changes can be seen when a grease gun is involved. Similar accidents have occurred with paint and with solvents used in cleaning spray guns. The radiolucency of the latter two substances is much less than with air or grease, pain is severe and the results often disastrous.

Submitted by
THOMAS C. BROWN, M.D.
HAWAII RADIOLOGICAL SOCIETY

In Memoriam – Doctors of Hawaii

HAWAII MEDICAL JOURNAL

This is the eighty-eighth installment of In Memoriam—Doctors of Hawaii.

Henry Chorley Watt

Henry Chorley Watt was born in Liverpool, England, January 29, 1872. He was educated in England and in 1895 became a licentiate of the Apothecaries' Society of London.

When Dr. St. David G. Walters, the English physician who practiced in Lihue, Kauai, for some 15 years, took a six months' leave of absence to return to England for a visit, he arranged for young Dr. Watt to come out and take over his practice while he was away. Dr. Watt arrived aboard the S.S. "Alameda" on March 13, 1897, and Dr. Walters stayed just long enough to show his colleagues the ropes and then left. Dr. Watt had a married sister, Mrs. William Fisher, living in Lihue, and was soon a part of the social life of the community. He upheld the honor of his native land by playing both golf and cricket.

While still in England Dr. Walters decided to resign his Board of Health position at Lihue and settle in Honolulu upon his return. This left the way clear for Dr. Watt, who decided to remain at Lihue. He became the permanent government physician for the district and was also appointed meat inspector. In 1899 he made a three months' trip to the Mainland.

After six years at Lihue the doctor resigned his position and left to settle at Colorado Springs, Colorado. A few days before leaving Honolulu he was granted American citizenship. On November 26, 1903, Dr. Watt sailed on the S.S. "China" for San Francisco.

Shortly after arriving at his destination he became the personal physician of General William J. Palmer, influential and wealthy founder of Colorado Springs. In the course of ministering to the General, Dr. Watt got to know the other members of the family and found the youngest daughter, Marjory, particularly appealing. Although his health was precarious, the General wished to accompany the rest of the family to England, where Marjory was to be married to a Captain Wellesley in September, 1908. The party which sailed for England was a large one, including, in addition to the members of the family, Dr. Watt and fourteen nurses, secretaries, and servants. Half way across the Atlantic, Marjory confessed to her father that she couldn't marry Captain Wellesley because she was hopelessly in love with Dr. Watt. So the wedding was off, and instead the whole party toured Europe.

On September 14, 1909, the doctor and Miss Palmer were married in Colorado Springs. It was a quiet affair, limited to immediate family members, due to General Palmer's death a few months previously.

Their life together lasted eight short years. On December 1, 1917, Dr. Watt died at Colorado Springs at the age of 45.

He was a member of the Colorado State Medical Society and the El Paso County Medical Society, belonged to the Colorado Springs Golf Club, and was a Mason and a member of the Coburn Library Book Club committee. Golfing was his favorite recreation, and he spent much of his time on the links.

During his years in Colorado Springs, both the doctor and Mrs. Watt were very interested in the Sunny Rest Tuberculosis Sanatorium. The second building at the Sanatorium was named after Dr. and Mrs. Watt in appreciation for their interest and financial aid. After Dr. Watt's death, his widow turned over to the directors of Sunny Rest her home, valued at $200,000, securities worth $110,000, and some cash to provide a permanent endowment for the Watt Memorial.

Franklin Burt

Franklin Burt was born in Paris, Ontario, Canada, on March 5, 1854. In 1879 he graduated from the University of Toronto with a Bachelor of Medicine degree. According to University of Toronto records, his M.D. was received in 1889, but the institution granting that degree is not known.

As a young man, Dr. Burt moved to Norwalk, Ohio, where he lived for a number of years. In June, 1905, the doctor came to Hawaii from southern California, where he had been in prac-

continued page 66

Postage will be paid by Addressee

No postage stamp necessary if mailed in the United States

BUSINESS REPLY MAIL
First Class Permit No. 134, Fairview, N.J.

Becton-Dickinson and Company
Consumer Products Division
P.O. Box 183
Fairview, New Jersey 07022

THE LEADING MANUFACTURER OF INSULIN SYRINGES

B-D

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY 0707

Clip coupon on dotted line . . . fill out other side send for physician's free samples

color-coded caps and numbers—red for U40, green for U80

presterilized—consistently dependable, and sterility is assured until cap is opened

easy-to-hold, easy-to-handle—even for child diabetics with small hands or adults with stiff fingers

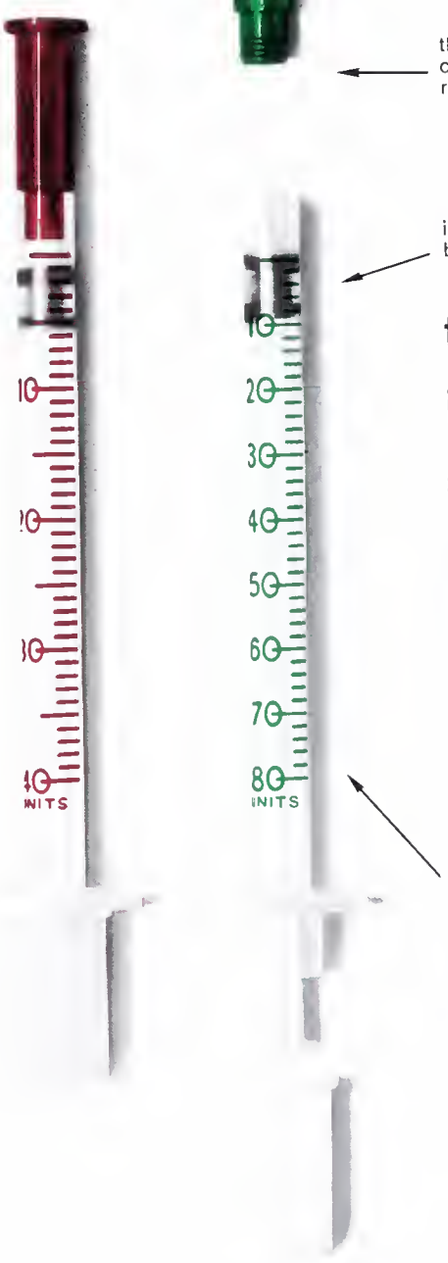
the sharpest needle your patient can buy—far sharper than any reusable needle

pocket-or-purse portable—sturdy from tip to top

integral cannula reduces air bubbles

single-scale PLASTIPAK insulin syringe needle units eliminate the hazard of reading the wrong scale

the first insulin syringe so low in cost your patient can use a new one every time



low cost—barely pennies higher than old-fashioned disposable needles without syringe . . . about as low as a cup of coffee

its single-scale—U40 or U80—minimizes the risk of measurement errors. Your patient *can't* read the wrong scale.

big numbers, wide spaces for easy reading

Supplied: in packages of 10—
PLASTIPAK syringe U-40 (red) or
PLASTIPAK syringe U-80 (green)
Prescription required in most states.

BECTON B-D DICKINSON
Consumer Products Division
Becton, Dickinson and Company
Rutherford, New Jersey 07070

U40 **U80**

THE LEADING MANUFACTURER
OF INSULIN SYRINGES

B-D

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY 07070

FREE CLINICAL SUPPLY

PLASTIPAK
INSULIN SYRINGE/NEEDLE UNITS

Send samples to:

Name _____
(Physician's Signature

Address _____

City _____ State _____ Zip _____

Clip out postcard on dotted line . . . no stamp required

Now you can lower the risk of insulin error when your patient is home . . . and alone



B-D

SINGLE-USE
PLASTIPAK
INSULIN SYRINGE/NEEDLE UNIT

8401
RED CAP u40

8406
GREEN CAP u80

as specific as insulin itself

HAWAII MEDICAL JOURNAL

★Foetal Autonomy; A Ciba Foundation Symposium

Edited by G. E. W. Wolstenholme and Maeve O'Connor, J. & A. Churchill, Ltd., $8.40, 1969.

AUTONOMY HAS BEEN variously defined, but the implication inherent in the title of this symposium is the ability of the "foetus" to maintain his own internal environment.

The symposium brings together a number of authors who have a broad range of interests, and who collectively are able to cover many aspects relating to adaptation of the fetus to his enclosed environment.

While the content of the papers varies from such relatively straight-forward titles as "The development of the foetal lung," to the more complex "Genetic assimilation of environmental variability in the organization of behavioral capacities of the developing nervous system," all the papers are of good quality, and some amazingly concise. At the end of each paper there is a section devoted to discussion by the participants, and some of the most interesting reading is in these sections.

This is not a book for the average physician to browse over at the breakfast table, since much of the content requires background knowledge and careful reading. On the other hand, it appears to provide the interested obstetrician or pediatrician with up-to-date information in a single volume even if some of the facts are debatable and hypothetical at the present time (the symposium was held in December, 1968, and published in 1969).

One of the advantages for the casual reader is a summary at the end of each paper, and an introduction and closing remarks by the chairman (Dr. G. S. Dawes), which provide the established facts in a concise and easy-to-read form.

While many areas do not receive attention, or only minimal coverage, the presentations should provide entertaining reading for the interested physician, even if he is in a "minority group."

ALISTAIR G. S. PHILIP, M.D.

Handbook for Scorings of Rorschach Responses

By Cecile Beizmann, 244 pp., $9.50, Grune & Stratton, 1966 (translation: 1970).

THIS IS a compilation and highly developed discussion of Rorschach responses and methods of scoring them according to Beck's system. It was developed, however, primarily for use with a French adult population by French clinical psychologists. It seems likely that Dr. Beck has chosen to translate it primarily because it leans so heavily upon his own work in general, and his scoring system in particular. Considering that there are other manuals and handbooks already available in the United States, this seems like "gilding the lily." It is somewhat more detailed and is extremely well done and of course does have the unique quality of relying so heavily on Dr. Beck's work. For Rorschach specialists, and particularly Rorschach specialists of Beck's persuasion, it is of some interest. For the general clinical psychologist, it seems unlikely to add enough to the existing English material to justify the $9.50 purchase price.

JEROME I. BOYAR, Ph.D.

★ means highly recommended.

Body Fluid Replacement in the Surgical Patient: An International Symposium, 1969

Edited by Charles L. Fox, Jr., M.D., and Gabriel G. Nahas, M.D., $25.00, 349 pp., Grune and Stratton, 1970.

THIS IS a collection of papers dealing with a subject upon which a vast amount of research effort has been expended and in which there is little unanimity of opinion. The problem with arriving at an easy answer to fluid replacement in the surgical patient is the great number of variables involved, such as type and extent of injury, age and overall condition of the patient as well as the inability to measure directly the exact parameters of certain basic fluid compartments, such as the extra-cellular fluid space.

Each set of papers proved its point well when limited to the confines of the particular experiment and the reader can learn much from this, but one must be careful about making generalizations in overall fluid replacement based on the conclusions of a particular paper. Many of the authors are tempted to do this and unfortunately the discussions, which are the weak point of the symposium, too often fail to bring this point out and set things in proper perspective.

The last section of papers deals with a comparatively new subject, *High Caloric Solution for Parenteral Feedings.* This is a rich field for investigation as most of the intermediate metabolism of handling the substrate loads is not understood. The development of the technique by Dudrick and Associates has been a milestone in the adjunctive management of surgical patients.

JOHN F. BALFOUR, M.D.

★Principles of Industrial Therapy for the Mentally Ill

By Bertram J. Black, M.S.W., 190 pp., $9.75, Grune and Stratton, 1970.

MR. BLACK, as professor of psychiatry (rehabilitation) at the Albert Einstein College of Medicine and as a consultant to rehabilitation services in New York City as well as director of mental health rehabilitation services, presents a timely and comprehensive discussion of mental health rehabilitation. He presents history, concepts as well as practical working models, of this therapeutic approach. The psychological as well as the economic aspects of rehabilitation is discussed with a minimum of complexity.

It is hoped that this publication will further public and professional interests in the expansion and intensification of this very important and long neglected social movement in our country.

HENRY K. WATANABE, M.D.

Clinical Aids in Cardiac Diagnosis

By William Dressler, M.D., 246 pp., illus., $12.75, Grune & Stratton, 1970.

THIS EXCELLENT TEXT stresses the needs and benefits of the historical and yet reliable methods of bedside diagnosis in this age of instrumentation and computerization. Cardiac symptoms and angina pectoris, which are so dependent on a good history, are lucidly discussed. Sig-

continued page 66

Notes and News

HENRY N. YOKOYAMA, M.D.

HAWAII MEDICAL JOURNAL

Life in These Parts

During a West Maui meeting on the water supply problem, **William Iaconetti** described the present water supply as a potential source of oral-fecal contamination. He learned that people lived in or very close to watershed areas and that there were eyewitness reports of wild pigs drinking from and defecating in West Maui water sources.

U of H School of Public Health's Roy Smith reports that an average of 9.4 abortions (and 46 deliveries) a day have been performed in Hawaii's hospitals since the liberalized abortion law went into effect March 13. The age range was from 13 to 46, but most of the patients were in their late teens and early 20's. The most frequent reason given was that the patient was not married. There were 4.1 per cent minor complications, but no maternal deaths. For more than half of the patients, the abortion terminated their first pregnancy. Eighty-five per cent of the operations were performed by the twelfth week of pregnancy. Most operations cost between $350 and $400.

This report reminds us of HMA executive secretary **Tom Thorson's** experience. Tom relates: "I got this long distance call from a fellow in LA. He wanted to know if his sister could get an abortion here in the Islands. . . . I told him that there was a 90-day waiting period . . . He then wanted to know if they 'prepped' the patients for abortion (i.e. if the patients were shaved). I asked 'why?' and the caller informed me that she didn't want her husband to find out." Tom was understandably a little taken back . . . (We later learned from **George Goto,** who had spearheaded our abortion law, that it was no longer necessary to prep for abortion. . . . Now . . . for whatever this information is worth . . . the husband need not know.)

Oops, My Slip Is Showing . . . A memorandum from the Queen's Medical Center read as follows: "Physician's orders . . . Important instructions: 1. Please indicate medication, dose, frequency and *toute* of administration . . ." (Ed.: tout à vous, i.e. "at your service") *God and the Postman work in mysterious ways* . . . Darned if a package addressed to "Dr. F. H. Pudauaga, Assoc Path; Kuekin Hospital; 347 N. Muskind St. Honolulu, M.I. 96817" didn't actually reach **Frank Fukunaga** at Kuakini Hospital, 347 N. Kuakini St. (Perhaps the correct Zip Code helped.)

The "Massachusetts Physician," which has been carrying histories of medical societies, carried an article on the Hawaii Medical Association in its Oct. issue, contributed on request by our Editor **Harry Arnold Jr.** . . .

Jordan Popper was describing how he and fellow neurologists were bombarded by patients wanting to use Dilantin for depression after the infamous Dreyfus articles in the popular medical journals, *Time* and *Life*. And Jordan admitted, "And darn it if it initially doesn't have some benefit . . ."

Miserable and cold despite the hot showers after being drenched on the 12th hole, we just felt like complaining about everything in general as we sipped our drinks in the Mid Pac lounge. **Yasuyuki Fukushima** was complaining about the increase in locker fees and how he had to pay double because his wife Eleanor had her own locker as well. Yet Fuku looked somewhat askance when we suggested that he can economize by sharing his wife's locker and shower facilities . . .

At a Children's Hospital Tissue Committee meeting, the chart reviewed was that of a 10-month-old infant girl who had a plastic repair of a previously corrected imperforate anus and had a hypertrophied right labium majus trimmed to match the other. Chairman **Ben Tom** wondered, "What is the objection to the hypertrophied labium? It could be a good thing . . .'" (This reminded us of the story of the Chinese man with the label "Wun Hung Lo, Wun Hung Hi" because of asymmetrical scrotal sacs) [Doesn't everybody?—ED.].

At a recent Queen's Quarterly meeting, **Jim Marnie,** our original utilization committee chairman, was back with his same "let's-get-them-out-because-we-need-beds" pitch and pointed out that HMSA, agent for Medicare Part A, was now denying coverage of some of the acute care days retroactively (though they have been doing this for some time for extended care facilities). Chief of Staff **K. Y. Lum** asked, "Wonder why they consider the *average* length of stay per illness the same as the *maximum* length of stay?" Jim effused, "It is peculiar, but then HMSA's position is economics and the physicians' position is compassion and care for the patient. . . . Some of you may have menstrual cramps and backaches, but these don't count. . . ." With this, K.Y. thanked Jim for his excellent work and appointed him for yet another term. . . .

Visiting Physicians

We found **Theodore H. Spaet,** U of H visiting professor and prof of medicine at Albert Einstein College of Medicine, N.Y., to be a rugged-featured, slightly jowled, frog-voiced lumberjack type with short-cropped, greying hair and prominent midriff, who lectures sans slides and instead scribbles symbols on blackboards. He prefers to lecture in a classroom atmosphere, and insisted on the Queen's mauka wing lecture room where the din of construction next door added to the already complex nature of hematology. He did condescend to do one Friday morning lecture in the Kam Auditorium where we listened to **Bob Jim** introduce him as a "blood coagulationist." Ted spells "haemophilia" (with an "ae") because "I feel British" and introduced his talk "as being like a wedding, i.e. 'Something old, something new, and a considerable amount borrowed.'" Herein are a few "Spaetisms" we gathered between the occasional lulls in the din of riveting hammers. . . .

re blood fractionation: "At Armour, when they kill a pig, they use everything but the squeal."

re cryoprecipitates: "I call this the 'Herbert Hoover phenomenon' because Judy Poole and her associates have for 10 years been reporting that a good cryoprecipitate was just around the corner."

re transfusions: "Transfusion of whole blood is very rarely indicated in 1970. If there is a platelet deficiency, give a platelet transfusion. If there is anemia, give cells. . . ."

re coagulation defects: "With congenital defects, there is a single disorder, whereas with acquired defects, there may be multiple disorders. . . ."

re vit K deficiency: "With any disorder other than coumadin intoxication, 1 mg of vitamin K is adequate. Giving excess water-soluble K is tantamount to malpractice. . . ."

Ted also referred to a Churchill "blood, sweat and

tears" syndrome and a Woolworth (five and dime) syndrome, but we missed their significance, what with the riveting and our backrow seat. . . .

Medical evangelist **Fred Ansfield** from Wisconsin, a friendly, mousy, frontal-alopecic lecturer with cracking voice and constantly blinking eyes, was back in Hawaii through the auspices of the RMP and **Jack Keenan's** efforts and lectured to capacity crowds for over a month at the various hospitals. Herein are some of his quotes:

"When chemotherapy has failed on a patient, we don't lie, but tell a 'half truth' and continue with an experimental drug." **Tom Fujiwara** was curious and started to say, "When you say drug failure . . ." whereupon Fred interrupted, "I would rather not use that word. . . ."

re intraarterial 5 FU results: (sotto voce) "If anyone else had better results than us, we would not quote it."

"In Wisconsin, over 90% of patients with advanced disease have cancer chemotherapy. The hope is that in the future, all candidates will have a trial of chemotherapy. . . ."

"In attempting to hide the disease from a patient, we jeopardize our relation between physician and patient and physician and family. . . . We could say, 'We couldn't remove all of your cancer, so we should give further treatment.' . . . Some internists feel that they should wait till symptoms start, when most of the cancer has been removed, but this is poor practice. Chemotherapy should be started immediately. . . . To procrastinate simply increases the risk."

re GI cancer: "No drugs are available today for GI cancer other than 5-FU."

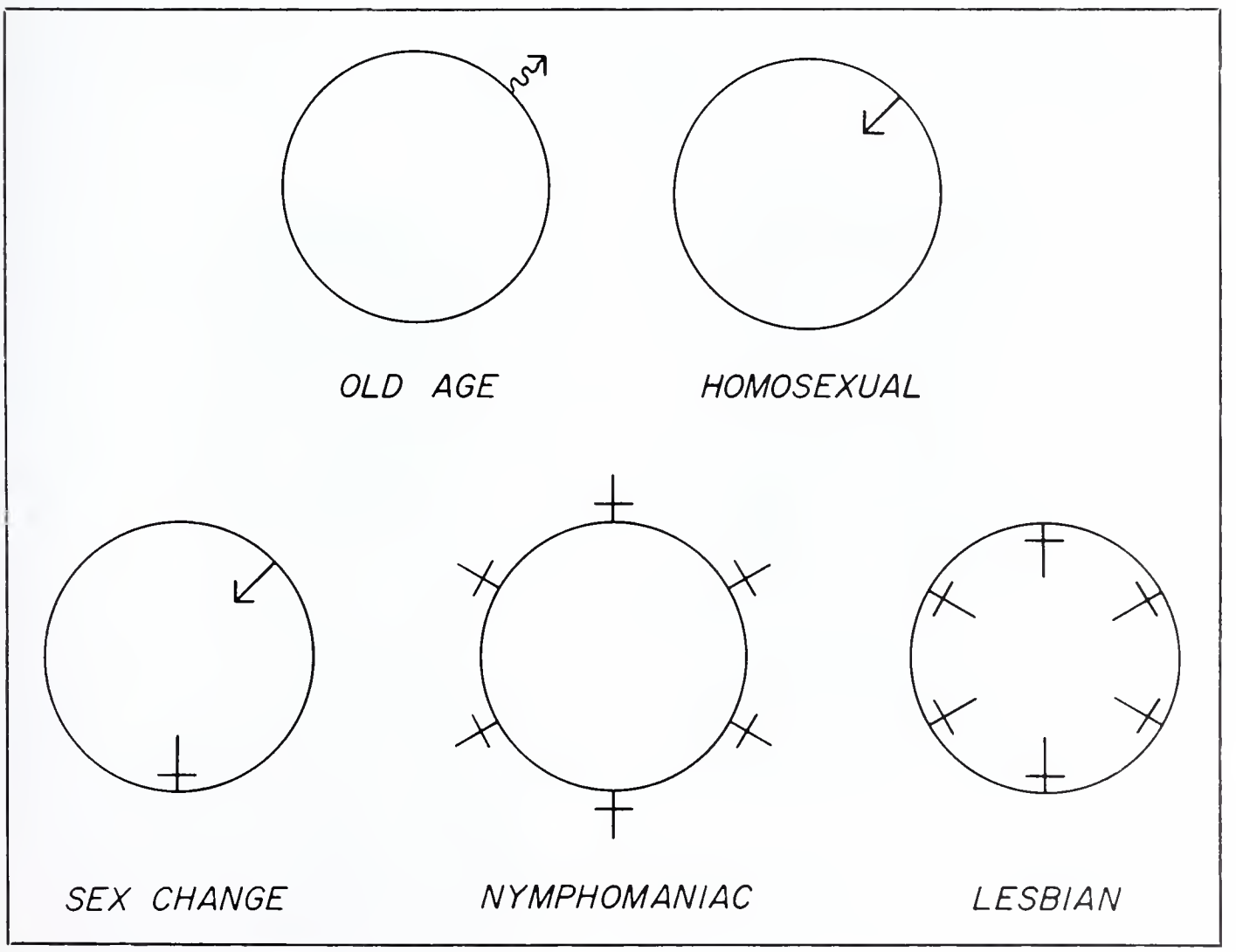
"When a lesion does not respond to 5-FU, a trial with an experimental drug is a great deal better than not treating at all."

In December, **George Griffith,** grey-haired, spunky professor emeritus of medicine at USC, spoke at a Queen's Friday morning conference. George, we were reminded, was the Queen's visiting cardiology professor several years ago who suffered a severe coronary while here and **Ed Chesne,** his former star resident, pulled him through after constant bedside vigil for several days. Subsequently Ed accompanied him back to America, where George had had heart surgery.

re Effler's reverse vein bypass graft: "This is the best closed-heart revascularization procedure." He recommends, "On any young patient with angina, do a ciné first and then do a reverse vein bypass graft. . . . The veins at post look like arteries, though we have only had two come to post thus far."

re cardiogenic shock not responding to medical management: "Since 80% who go into cardiogenic shock after an MI die, put him on a pump, look for a ventricular cavity, and resect." From his own personal experience, he comments ruefully, "My friends kept patting me on the back and repeating, 'George, you will get well.' . . . But when you drop from 170 lbs to 127 lbs and still remain in failure, you begin to despair. . . . The happiest moment of my life was when they put me on the pump and removed the akinetic segment. . . . I hope you young people will not be as timid as we older people are in resorting to surgery. . . . Do not wait for the point of no return. . . . The term 'myocardiectomy' should come into our vocabulary. . . ." (Imagine, an internist speaking like a surgeon. . . !)

continued page 56



New Members

HAWAII MEDICAL JOURNAL



Eugene S. Kostiuk, M.D.
1110 University Avenue, Suite 510
Honolulu, Hawaii 96814
PSYCHIATRY
Northwestern University—1960
Internship—Cook County Hospital—1960-1961
Residency—USN Hospital, Oakland, California—1962-1965



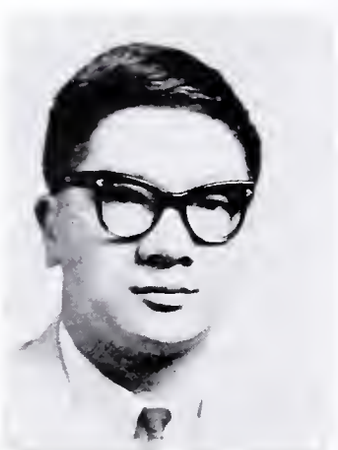
Amelia R. Jacang, M.D.
226 North Kuakini Street
Honolulu, Hawaii 96817
PEDIATRICS
University of the East R. M. Memorial Medical Center, Philippines—1963
Internship—Kuakini Hospital—1964-1965
Residency—New York Polyclinic Hospital—1965-1966
St. Christopher's Hospital for Children. Philadelphia—1966-1967



George N. Lewis, III, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
GASTROENTEROLOGY
INTERNAL MEDICINE
University of Maryland—1959
Internship—Madigan General Hospital—1959-1960
Residency—Tripler General Hospital—1960-1963



Edmund F. Longworth, M.D.
99 South Market Street
Wailuku, Maui 96793
OBSTETRICS-GYNECOLOGY
New York Medical College—1937
Internship—Flower & Fifth Avenue Hospital, New York—1938-1940
Residency—Metropolitan Hospital, New York—1940-1941



Eugene N. Wong, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
ANESTHESIOLOGY
Heidelberg Medical School—West Germany—1961
Internship—Carney Hospital and St. Margaret's Hospital, Boston—1963-1964
Residency—Carney Hospital and St. Margaret's Hospital, Boston—1964-1965
Monson State Hospital, Boston—1965-1966
Boston V.A. Hospital, Boston—1966-1968

County Society News

HAWAII MEDICAL JOURNAL

Hawaii

The October 21 meeting was held at the Hilo Hotel. Guests, Drs. Arnold W. Siemsen and Livingston Wong presented a most interesting discussion of their recent experiences at the St. Francis Hospital with renal dialysis and transplantation. Mrs. Yoshihara (Hilo) who has been on renal dialysis for one year and at home since April was presented to the group. She is an excellent example of what the benefits of home dialysis can accomplish.

Dr. Ron Hattis discussed the Hilo Rubella Immunization Project. The group concurred with the request to do immunization studies on the 8th and 9th graders at the same time as the study group is being studied.

It was duly moved, seconded and carried that the recommendations of the Constitution and By-Laws Committee be approved. The recommended changes would make provisions for inactive membership in the Society.

Dr. Bracher announced that the Board of Medical Examiners would be meeting in Kona in November and a representative of the Society has been invited to attend this meeting.

It was reported that two individuals are currently receiving scholarships from the Society's scholarship fund.

* * *

Dr. Sidney C. Werner, Professor of Clinical Medicine, College of Physicians and Surgeons of Columbia University, gave an interesting and timely discussion on "Current Use of Tests in Thyroid Disease" at the November 18 meeting. A lively question and answer period followed.

Dr. Bracher reported on a communication he received relative to a public hearing on the proposed Workmen's Compensation reimbursement. It was duly moved, seconded and carried that the President write a letter to the chairman of the Workmen's Compensation Board protesting the paragraph in the proposal regarding the hospitals being forced to allow any physician to treat a Workmen's Compensation case in the hospital even though he is not a member of that hospital medical staff.

It was agreed that the forthcoming meeting of the Society with the local lawyers be confined to the subject of malpractice and what can be done to halt the high cost of malpractice insurance.

Dr. Caldwell presented a proposal for the training of residents in Community Medicine in conjunction with a mainland teaching situation. It was agreed that this subject should be explored further and Dr. Caldwell was so instructed.

It was duly moved, seconded and carried to adopt the By-Laws changes as previously distributed to the members as is required by the By-Laws.

* * *

The members, their wives and guests enjoyed the annual Christmas party held at the Hilo Yacht Club on December 17.

A short business meeting was held, presided over by Dr. George Bracher, President. The report of the nominating committee was read and accepted. The following officers were duly elected for the forthcoming year:

President	Verne Adams, M.D.
Vice President	DeWitt N. Smith, M.D.
Secretary	Edward Ballerini, M.D.
Treasurer	Allan Takase, M.D.
Delegate (1972)	James E. Mitchell, M.D.
Alternate Delegate (1972)	C. Hayashi, M.D.

There being no further business the official meeting was adjourned and an evening of fellowship and good food was enjoyed by all.

Honolulu

Approximately 105 members and guests were present at the October 6 meeting. The following new members were introduced: Drs. John W. Edwards, Jr., Eugene S. Kostiuk, Ernesto A. Orinion, Paul Sunahara, Neal E. Winn and Alice C. Dahlby.

Dr. Robert Millard was called upon to pay tribute to a member of the Medical Society, Dr. Chinami Hasegawa, who died on September 21, 1970. A moment of silence was observed by the membership.

Dr. Omura announced that another United Fund Drive was in progress and urged the doctors to contribute their fair share. The goal set for the medical profession this year is $43,000, and if every physician gave at least $150.00 that goal could easily be reached. Last year only 44% of the $36,000 goal set for the doctors was reached.

Mr. Thorson reported to the membership that the situation in the malpractice insurance field is anything but clear and that the picture at the present time is not a very pretty one. We continue to hear about doctors being refused renewal of their policies, and if they are granted a renewal, the premium rates have been increased considerably. This situation exists all over the United States. With regard to the AMA's attempt to develop a national program, it was announced in the last issue of the AMA News that negotiations with a brokerage company has fallen through and they are not going to be able to develop any program in the immediate future. At the present time there is one insurance carrier, Hawaii based, who will accept all classes, but at a rate that is not controlled by the insurance commissioner. There is some tentative assurance that another carrier will be coming into the islands and it is hoped that we will be able to stimulate some competitive outlet for our doctors. Another way of resolving the problem would be through corrective legislation. Both Mr. Miyoi and Mr. Honda are encouraging us in this area. Mr. Thorson urged the doctors to inquire of their agents about the status of their malpractice insurance with them, especially those doctors who are doing any kind of surgery.

Dr. Lowrey, President of HMA, presented to Dr. Truett Bennett a plaque on behalf of the American Medical Association, in recognition of his exceptional service performed for the medical profession, the U.S. Government, and the people of South Vietnam, while serving as a volunteer physician in Vietnam. This was Dr. Bennett's second tour under the program, Voluntary Physicians for Vietnam.

A presentation was made to the membership on a new service PMMS (Professional Medical Management Services) a joint venture of the Bureau of Medical Economics and Control Data Corporation. It was brought out that this new service was being offered to the doctors in response to requests for an automated, reliable, and effective accounts receivable and billing service. Mr. Leineweber of the BME and staff members of Control Data Corporation made the presentation. The membership was invited to ask questions of the representatives during and also after the meeting.

Dr. William Kirker presented an interesting talk on Africa relating his experiences as a medical director in Niger while administering to the medical needs of the

continued page 62

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: BETTY BELL, *Vice President:* NOEL EVANS, *Secretary:* NOLAN HASEGAWA, *Treasurer:* RICHARD HORI, *Board of Directors:* C. CACHERO, H. T. CHEE, B. CHOCK, E. ELKE, F. FRICK, R. NAITO, W. OGOMORI, J. TARASAWA, A. YEE, C. YEE.

The President's Corner

How do *we* pharmacists fit into the philosophy of the "now" generation? Do we react with violence and criticism when our particular little empire is threatened? Yes, some of us are guilty, but for the most part we stand back and review our problem and decide just what we really have to offer our fellow man—then act with positive conviction.

Many practitioners feel that the community pharmacy is doomed to extinction via centralized health care facilities. I strongly disagree. There is a need for centralized health care facilities and I'm sure that our profession will provide leadership in the area . . . but the community pharmacist has an awe inspiring mission to fulfill. A mission that requires our total commitment to the preservation of the public health. John Q. Public needs education and personal help on all facets of health care. You, community pharmacists, are the logical choice to provide this information, advice, and council. Can you measure up?

As you view your respective practices, consider the merchandise you know you shouldn't be stocking, take a close look at your prescription record system—does it fulfill information needs of physicians and patients? Do you personally assist patients in the selection of OTC's providing counciling required? Do you stock health aids and orthopedic supplies? Are you ready to participate in the *new* health care system? We *must* move now to prepare ourselves for active participation on the health team. We cannot justify the title "professional" while providing only a distribution function. It's time we pharmacists, regardless of discipline, worked together for the ultimate benefit of the patient. The clinical pharmacist should be able to contact the community pharmacist for a complete admission summary of the patient's drug history . . . the patient could well be saved an extra inpatient day . . . if the physician knew that laboratory "procedure x" was false positive because the patient had been taking "Brand y" cold formula just prior to admission. In the same respect a discharge medication summary from the clinical hospital pharmacist to the community pharmacist would insure continued chemotherapeutic monitoring in compliance with the physician's order. Why not act positively . . . now?

As a profession we must know what is right and persist in doing the right thing voluntarily. We must resist the pressures of greed, cynicism, and loss of confidence so commonly viewed in our society today.

Lest we forget that . . .

The greatest investment the profession of pharmacy can make is in the lives of others.

Board of Directors Meeting

On October 10 a meeting of the Board of the Hawaii Pharmaceutical Association was called to order at the Queen's Hospital by Vice-President Noel Evans. Those present were: N. Evans, R. Hori, C. Cachero, A. Yee, G. Bear, J. McElhiney, and L. Wong.

CORRESPONDENCE:

1. The Internal Revenue Service received our application and will transmit it to the District Director in Los Angeles for consideration. The office will communicate with us regarding the processing of our application.
2. We have received letters of appreciation from the U. of Washington, the U. of So. California, and Creighton University in regards to our scholarship funds for their students.
3. The Board of Health (Mr. Lee) sent us a letter in regards to the FDA's stating that stramonium containing products labeled with directions for self-medication are misbranded. The FDA regards these as prescriptions and will consider prosecution of those who are selling them over the counter.

STANDING COMMITTEE REPORTS:

1. *Seminar:* Tape recordings of the seminar are available to members who wish to use them. They may be obtained from the executive secretary on a loan basis. We have a refund of $363.18 from the proposed seminar budget.
2. *Membership:* A second letter is being sent out to delinquent members.

NEW BUSINESS:

International Narcotic Conference: Mr. A. Fraga has come to the Association for help in transportation of the international delegates from their hotels to the Governor's residence. It was suggested that we donate $500 to cover transportation costs. It was also suggested that the Association pay the $40 registration fees for President Bell or an appointee by the President and for Jim McElhiney, Drug Abuse Committee Chairman.

* * *

On November 13, 1970 at 7:30 P.M. the monthly meeting of the Board was called to order by President Bell at Queen's Hospital. Those present were: B. Bell, B. Chock, E. Ehlke, N. Evans, F. Frick, N. Hasegawa, R. Hori, W. Ogomori, J. Tarasawa, C. Yee, J. McElhiney, H. Urashima, G. Pang, and G. Bear.

The minutes of the October meeting were approved as read except for one minor correction.

The treasurer's report was approved as read.

OLD BUSINESS:

1. The Board approved the proposal of the Ethics Committee. This committee will be made up of 5 members:
 (1) the President of the HPhA.
 (2) & (3) appointees by the President of the HPhA with overlapping terms.
 (4) President of the Board of Pharmacy or an appointee.
 (5) a non-pharmacist with the approval of the Board of the HPhA.
2. Poison Control—C. Yee has obtained a sample of a

poison control kit which has been used by the Michigan Pharmaceutical Association. This kit contains one ounce of Ipecac syrup and an ounce of activated charcoal powder. Several means of distribution were discussed such as distribution through MD's office, by Rx, by drugstores, and the poison control center.

3. Pharmacy Directory — The directory information sheets are coming in.

COMMITTEE REPORTS:

1. Legislative—Glenn Pang is to be co-chairman for W. Ogomori. A questionnaire about licensure is to be sent out to all pharmacists.
2. Program—H. Urashima reports that there will be no quarterly meeting in December. The meeting will probably be held in January. A seminar on contraceptives is also scheduled for January.
3. Drug Abuse—J. McElhaney attended the International Narcotic Convention as a representative of the HPhA.

* * *

On December 12 the monthly Board of Directors meeting was called to order at 7:45 P.M. by President Bell at Queens Hospital. Those present were: B. Bell, H. T. Chee, E. Ehlke, N. Evans, N. Hasegawa, R. Hori, J. Tarasawa, A. Yee, K. Miller, G. Pang, G. Bear, and O. Turk.

The minutes of the November meeting were approved.

CORRESPONDENCE:

1. The association received a letter of appreciation from the University of Washington for scholarships for their various students: Christopher Ogawa, Yvonne Sur, and Margaret Tam.
2. The Board's opinion is to favor the universal claims form instead of the standard claim forms.

TREASURER'S REPORT:

The treasurer's report was approved as read.

GUEST SPEAKER:

Mr. Marvin Hall from the HMSA briefed the Board in regards to DSS claim forms. The HMSA will be processing all DSS claims as of January 1, 1971. The claim form is very similar to the present HMSA claim form.

COMMITTEE REPORTS:

1. Membership: There are presently 138 active and 39 associate members.
2. Legislative: Presently the majority of the answered questionnaires are in favor of changing the licensure laws. More questionnaires will be sent out to the remaining members.
3. Convention: O. Turk reports that several journals have publicized the Hawaii Convention to be held April 2 to 5, 1971. He has also received monetary contributions from several manufacturers.
4. Seminar: The seminar will be held January 11, 1971 at Shriner's Hospital. The School of Public Health will sponsor a seminar on contraceptives and family planning.

UNFINISHED BUSINESS:

1. Meyer's Collection: Pres. Bell has acquired a written agreement from Mr. Meyer stating that he will sell his Hawaiian Pharmeceutical Artifact Collection including the two King Kalakaua prescriptions to the HPhA as inventoried by the Bishop Museum for a total sum of $3,000.00.
2. Pharmacy Directory: G. Bear reported that the Pharmacy Directory will be printed shortly.
3. Addressograph Machine: The board approved the purchase of an addressograph machine and set the maximum cost at $250.00 for the basic machine.

ADJOURNMENT:

10:00 P.M.

NOLAN HASEGAWA
Secretary, HPhA

Rx Notes of Interest

The National Association of Boards of Pharmacy is formulating a *Directory of Pharmacists in the United States*. Each pharmacy will be designated by a six digit code designating the state in which the pharmacy is located and the type of outlet. National utilization of the NABP J.D. code could be a position step in the elimination of drugs to outlets that do not exist.

Pharmacists have always beeen encouraged to cooperate with law enforcement officers. We are indeed proud of our own "prn" (Expl. abbreviation) and James McElhaney communication system for sharing abuse information among our colleagues.

APHA Legal Director Carl Roberts warned pharmacists not to provide aid to agents in abetting illegal drug traffic unless they protect themselves with objective evidence. If you lend an enforcement agency a hand, advise the Hawaii Board of Pharmacy and the Hawaii Pharmaceutical Association of your intention prior to the assist.

The Virginia Supreme Court handed down a decision holding that the Blue Cross third party drug prepayment plans utilizing a uniform fee constitutes price-fixing and is contrary to both state and federal statutes. Unless this decision is appealed to the Supreme Court, third party participation in the drug distribution system of this country will likely experience an appreciable delay.

ARTHRITIS—A Reference Report from
Lederle (abstracted)

17 million Americans suffer from some form of rheumatic diseases. The most common being rheumatoid arthritis and osteo arthritis.

We still do not know what causes arthritis nor do we have a cure. Rheumatoid arthritis most often strikes persons between the ages of 20 and 50 years, and more women than men. Inflammation and pain begin to surround the affected joints. An increasing amount of fluid in the joint coupled with a thickening of the surrounding synovial membrane produces swelling, causing destruction of the joint tissue, increasing pain and a decrease in mobility. The disease can be effectively treated if diagnosed early.

Osteo arthritis is much more prevalent than rheumatoid arthritis, but much less serious. The disease is commonly associated with old age and is generally described as gradual deterioration of the joints, particularly those joints sustaining an abnormal amount of wear and tear. Essentially the cartilage cushion attached to the ends of the two joints breaks down with resulting pain and swelling.

Essentially arthritis is treated with salicylates, pain relievers, gold salts, antimalarials, carticosteroids, and other chemotherapeutic agents.

In terms of the effect on the national economy, the estimated cost of rheumatic diseases is over $3.5 billion a year in loss of productivity, in financial support of the disabled, and in medical and related costs.

* * *

Daring ideas are like chessmen moved forward; they may be beaten, but they may start a winning game.

Goethe

* * *

Indian Prayer

Great Spirit
Grant that I may not
criticize my neighbor
until I have walked a mile
in his moccasins.

FDA Action

The Food & Drug Administration has indicated that the benefit-to-risk of certain antibiotics containing antidiarrheal preparations is unfavorable. Such nonabsorbable drugs such as neomycin and the streptomycins may be absorbed from as inflamed or diseased gastrointestinal tract and result in eighth cranial nerve toxicity. There is a possibility of hypersensitivity and blood dyscrasis with sulfonamides; resistant strains of organisms may develop from unnecessary use of an antibiotic mixture; and the dosage is not flexible enough to safely achieve the desired effects from individual components. Products affected: Streptomagma, Polymagma, Kectil, Strycin, Donnagel with Neomycin, Sorboquel with Neomycin, Cremomycin, Kaomycin, Quintess-N, and Pectin-neomycin Suspensions (Vitamix Pharmaceutics, Inc. & Eu Heun Co.'s). The FDA also proposes to withdraw the NDA of Cyclex, Pree-MT, Protamide injection, and Visciodal Suspension.

Caution on Using the PDR

The Food & Drug Administration working with the National Academy of Sciences in Washington, D.C., has been critically reviewing the usefulness of drugs for their claimed spectrum of efficacy. The reports that come from these agencies are termed the drug efficacy reports. Consequently, the write ups in the *Physicians' Desk Reference* are not, in MANY cases, up to date. The FDA considers misleading the information present in some package inserts and in the DPR incomplete *in presenting* the vital information for safe and effective use and in some cases, *fraudulent*. The PDR contains biased information on drugs; this information is submitted and paid for by the drug industry.

Div. Central Services,
University of Wisconsin, Sept. 1970

Guided Toxin to Combat Cancer

Two scientists from Boston University have now shown that cultured monkey cells infected with mumps virus are destroyed when treated with diphtheria toxin conjugated to guinea pig mumps virus antibody. Next step is to find out whether human tumors contain enough antigenic sites on their surfaces so that enough conjugated toxin could be hooked on to selectively destroy cancer cells. Alternately, cancer patients might be infected with a virus that would grow and produce antigens only in tumor tissue.

Medical World News, July 31, 1970

Food and Anesthesia May Be Fatal

From 5% to 8% of all maternity deaths are caused by aspiration of food-vomiting into one's own lungs according to Dr. A. H. Giesecke, professor of anesthesiology, University of Texas. The situation occurs when the protective reflexes of the throat are dulled by anesthesia, allowing fluid and food particles from the stomach to get into the lungs when vomiting occurs.

The Pill and Cancer

With proper medical supervision, the pill at this time seems unlikely to be carcinogenic and because of regular check-ups its use may even help in early detection of cervical and uterine cancers. Although it is apparent to any woman on the pill that the breasts are affected there have been no reports of malignant neoplasms of the breasts attributable to the pill.

Medical World News, July 31, 1970

Teratogenic Effect of Trimethadione and Paramethadione

Researchers at Cornell University suspect congenital anomalies in children of two mothers taking tri and para methadione for petit mal seizures. They may represent cause and effect of the nine pregnancies ending in spontaneous abortion or abnormal children. When Dr. James German and associates withdrew the drugs during pregnancy normal children were born.

Although evidence is impressurea, definitive conclusion must await further data.

Lancet, Aug. 1, 1970

News of Our Colleagues

Dan Moriyasu has left Maui Medical Group in Wailuku to work for Maui Memorial Hospital. Jack Pawol will be taking Dan's place at Maui Medical Group.

INSURANCE EXCLUSIVELY

Brainard & Black, Ltd.

1712 S. King Street, Honolulu 96814

Telephone: 949-0031

"Small enough to know you,
Large enough to serve you"

HAWAII MEDICAL ASSOCIATION

115th ANNUAL MEETING -- 1971

Ilikai Hotel—Pacific Ballroom—Honolulu, Hawaii

THEME: NEW CHALLENGES TO CHRONIC DISEASE

PRELIMINARY SCIENTIFIC PROGRAM

TUESDAY, APRIL 27

MORNING

7:30 AM Call to Order by John J. Lowrey, M.D., President
Welcome by R. Varian Sloan, M.D., Chairman, Arrangements Committee

7:45 AM *"Obesity: Prevention and Treatment"* by Peter H. Forsham, M.D.

8:15 AM Intermission to view exhibits

8:45 AM Session A —*"The Modern Treatment of Diabetes Mellitus"* by Peter H. Forsham, M.D.
Session B — *"Serological Phenomena in Rheumatoid Arthritis"* by Morris Ziff, M.D.
Session C — *"Malignant Melanoma, Clinical Aspects and Management"* by John S. Stehlin, Jr., M.D.

EVENING

8:00 PM FIRESIDE CHATS (Hawaii Thoracic Society)
(Exhibits will be open.)

WEDNESDAY, APRIL 28

MORNING

7:30 AM *"Etiological Aspects of Rheumatoid Arthritis"* by Morris Ziff, M.D.

8:00 AM Intermission to view exhibits

8:30 AM Session A —*"A Rheumatoid Hyperviscosity Syndrome"* by Morris Ziff, M.D.
Session B — *"Intersex"* by Peter H. Forsham, M.D.
Session C — *"Regional Chemotherapy for Cancer"* by John S. Stehlin, Jr., M.D.

EVENING

7:00 PM *"Psychological Aspects of Cancer - To Tell or Not to Tell"* by John S. Stehlin, Jr., M.D.

7:45 PM Intermission to view exhibits

8:15 PM Session A —*"Chronic, Painful, Disabling Problems of the Foot"* by Rene Cailliet, M.D.
Session B — *"Why Me?" Common Behavior Problems in Children with Chronic Disease* by John F. McDermott Jr., M.D.
Session C — *"Old Skin, New Skin, Blue Skin, Red Skin"* by Norman Goldstein, M.D.

THURSDAY, APRIL 29

MORNING

7:30 AM *"A Rational Approach to the Treatment of Hypertension"* by Frank A. Finnerty, Jr., M.D.

8:00 AM Intermission to view exhibits

8:30 AM Session A —*"Anatomical Biomechanical Aspects of Joints and Their Relationship to Disease"* by Rene Cailliet, M.D.
Session B — *"Diagnostic Approach to Pleural Effusion"* by Kenneth M. Moser, M.D.
Session C — *"Asparaginase in Cancer Therapy"* by Joseph H. Burchenal, M.D.

EVENING

7:00 PM *"Symptoms and Treatment of Lumbar Discogenic Disease"* by Rene Cailliet, M.D.

7:30 PM *Presidential Address:* John J. Lowrey, M.D.

7:45 PM *Address by American Medical Association President,* Walter C. Bornemeier, M.D.

8:00 PM Intermission to view exhibits

8:30 PM Session A —*"Treatment of Acute Hypertensive Crisis"* by Frank A. Finnerty, Jr., M.D.
Session B — *"Diagnosis and Management of Chronic Obstructive Lung Disease"* by Kenneth M. Moser, M.D.
Session C — *"Areas of Promise in Cancer Problems"* by Joseph H. Burchenal, M.D.

FRIDAY, APRIL 30

MORNING

7:30 AM *"Management of Tuberculosis, 1971"* by Kenneth M. Moser, M.D.

8:30 AM Session A —*"New Frontiers in Pulmonary Medicine"* by Kenneth M. Moser, M.D.
Session B — *"Differential Diagnosis of Hypertension in Pregnancy"* by Frank A. Finnerty, Jr., M.D.
Session C — *"Burkitt's Tumor and Its Implication to Cancer"* by Joseph H. Burchenal, M.D.

ANNUAL SPORTS AND SOCIAL EVENTS

Bow & Arrow Hunting Tournament—April 23-25, 1971—Island of Hawaii
Tennis Tournament—April 25, 1971—Kam School & Beretania Courts
Deep Sea Fishing Tournament—April 25, 1971—Honolulu
Golf Tournament—April 30, 1971—Waialae Country Club and Oahu Country Club
Fifth Annual Sportsmen's Night—April 30, 1971—Waialae Country Club
Annual Woman's Auxiliary Luncheon—April 30, 1971—Home of Dr. & Mrs. Frank Gerbode
Annual Banquet—May 1, 1971—Pacific Ballroom, Ilikai Hotel

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

HOUSE OF DELEGATES MEETINGS

Tuesday, April 27, 1:00 P.M.
Ilikai Hotel

Thursday, April 29, 1:00 P.M.
Ilikai Hotel

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

GRATEFUL ACKNOWLEDGEMENT IS MADE TO THE FOLLOWING ORGANIZATIONS WHO MADE THE PROGRAM POSSIBLE

American Cancer Society, Hawaii Division, Inc.
Bristol Laboratories
Burroughs Wellcome & Company, Inc.
Ciba Pharmaceutical Company
Geigy Pharmaceuticals
Hawaii Heart Association
Hawaii Thoracic Society
Eli Lilly and Company
Parke Davis & Company
G. D. Searle & Company
Smith Kline & French Laboratories
Schering Corporation
The Upjohn Company

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

GUEST FACULTY

Walter C. Bornemier, M.D.
President, American Medical Association

Joseph H. Burchenal, M.D.
Professor of Medicine
Cornell University Medical College
New York, New York

Rene Cailliet, M.D.
Dept. of Physical Medicine
Southern California Permanente Medical Group
Los Angeles, California

Frank A. Finnerty, Jr., M.D.
Chief, Cardiovascular Research
Georgetown University Medical Division,
D.C. General Hospital
Washington, D.C.

Peter H. Forsham, M.D.
Professor of Medicine and Pediatrics
Chief of Endocrinology, Dept. of Medicine
University of California Medical Center
San Francisco, California

Norman Goldstein, M.D.
Clinical Professor of Medicine (Dermatology)
University of Hawaii School of Medicine
Honolulu, Hawaii

John F. McDermott, Jr., M.D.
Professor of Psychiatry
University of Hawaii School of Medicine
Honolulu, Hawaii

Kenneth M. Moser, M.D.
Director, Pulmonary Division
University Hospital of San Diego County
San Diego, California

John S. Stehlin, Jr., M.D.
Clinical Associate Professor of Surgery
Baylor University, College of Medicine
Houston, Texas

Morris Ziff, M.D.
Professor Medicine
University of Texas Southwestern Medical School
Dallas, Texas

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

December 11, 1970 — 5:00 P.M.
Mabel Smyth Conference Room, 2d Floor

PRESENT

John J. Lowrey, presiding; Herbert Y. H. Chinn, Thomas P. Frissell, George H. Mills, William W. L. Dang, Grover H. Batten, Ed B. Helms, William E. Iaconetti, plus Drs. George Goto, Cesar B. DeJesus, Winfred Y. Lee, Calvin C. J. Sia, Coolidge S. Wakai, John Watson, Sakae Uehara, J. I. F. Reppun, Richard T. Mamiya, Max G. Botticelli, and Alexander Anderson.

MINUTES

ACTION:

It was voted to accept the minutes of the September 18, 1970, meeting as circulated.

REPORT OF THE SECRETARY

ACTION:

It was voted to approve the Secretary's Report as circulated.

REPORT OF THE TREASURER

ACTION:

It was voted to approve the Treasurer's Report as circulated.

REPORT OF THE COMMISSIONS AND SPECIAL COMMITTEES

Commission on Education and Scientific Research: The repoprt was circulated, reviewed and discussed. The following recommendation was made: (1) That the Council approve the assignment of $1,000 to the Hawaii Medical Association's Study on the Quality of Personal Medical Care to be used for the hospital's seminars from the Medical Education Committee's budget.

ACTION:

It was voted to approve the assignment of $1,000 from the Medical Education Committee's budget to be used for the hospital's seminars.

Commission on Internal Affairs: The report was circulated, reviewed, and discussed.

ACTION:

It was voted to approve the report as circulated.

Commission on Medical Services: The report was circulated, reviewed, and discussed.

It was noted that the Department of Social Services has now contracted with HMSA to act as the fiscal intermediary. For the time being, the payment will be continued at a conversion factor of 5.0 based on the HRVS. It is hoped to make payment on the basis of the usual and customary fees, paying whatever percentile was possible under the available funds. Dr. Watson pointed out that the DSS has put into their budget for the fiscal year 1971-72 a request for increased funds to allow them to pay a larger amount to physicians for their services, and he stated that DSS would like the help of the Legislative Committee of HMA to back them up in the forthcoming legislative session.

It was further noted that the Maui County Medical Society has been requested by the DSS that physicians bill DSS at the conversion of 5.0 and that they do not bill at their usual and customary rate. It was pointed out that the HMA has encouraged its members to submit their usual and customary fees on all billings.

Mr. Thorson requested of the Council that he be given approval to meet with representatives of HMSA regarding their role and their plans as the fiscal intermediary for the Department of Social Services.

ACTION:

It was voted that Mr. Thorson set up a meeting with representatives of HMSA.

Commission on Public Health: The report was circulated, reviewed, and discussed. The following recommendation was made: (1) That Council approve the School Health Committee's proposal to sponsor a session on sports medicine directed to athletic coaches, trainers, and team physicians. It was reported that the format of such a session will be presented to the Council at its next meeting. It was further reported that funding for this session will be sought through private sources.

ACTION:

It was voted to appprove the School Health Committee's request to sponsor a session on sports medicine.

Commission on Interprofessional and Public Relations: The report was circulated, reviewed, and discussed. The following recommendations were made:

1. That Council approve financial support for the medical students' participation in the HMA Careers Day program.

ACTION:

It was voted to approve the cost of one meeting room and one booth for the medical students' participation in the HMA's Careers Day Program.

2. That Council advise the Public Relations Committee regarding the HMA Opinion Survey; i.e. what should be done with the questionnaire, what should be tabulated, and what should be done with the information.

ACTION:

It was voted to request the Public Relations Committee to tabulate and summarize the HMA Opinion Survey and make its recommendation to Council on what they plan to do with the results.

3. That Council appropriate funds to have one of the members of the Medicine and Religion Committee to attend a Conference in Salt Lake City.

ACTION:

It was voted not to approve the request for funds to send a representative to a Conference on Medicine and Religion in Salt Lake City.

Bureau of Planning & Research: The report was circulated, reviewed, and discussed. Also circulated was a report of a meeting with the team of consultants doing a feasibility study on a four-year medical school in Hawaii. There was considerable discussion on some of the questions asked at this meeting and due to the lack of information at this particular time, the Council took the following action:

ACTION:

It was voted to (1) defer action on the subject, (2) gather more information and circulate it to the Council, (3) discuss the circulated information at the next Council meeting, and (4) if an emergency arises in the meantime whereby the Legislature needs a statement from the HMA, that a special Council meeting be held.

Finance Committee: The report was circulated, reviewed, and discussed. The Finance Committee is still awaiting additional experience under the merger of the two staffs before making any final commitments. One of the problems has to do with two different retirement plans and the committee would like to recommend to the Council that it would like to merge the two programs, preserving the benefits of both. The alternative to this is to scrap both plans and start anew.

ACTION:

It was voted to merge the HCMS and HMA retirement plans.

It was reported that the change in the accounting periods to calendar year ending December 31 will have an adverse financial setback for the HMA. The year of the change, whether during 1970 or during 1971 will have a short year (July to December) a six-month operational period. This is the period of cash flow deficiency and operational deficiency. The membership dues, representing approximately 65% of the total receipts of HMA revenues, collects approximately 95% of the dues from January to June of each year. Therefore operation from July to December is maintained primarily on savings funds. The net operational loss from July to December 1970 is estimated to be $35,000.00. This loss is not recoverable during the following calendar year, but will reduce the net equity drastically. The following year operation will carry its own revenue and expenses whether it's an increase or a decrease in net operating fund. The estimated net operational loss constitutes approximately 37% of the entire surplus generated for the period of over 12 years. Council is asked to consider converting from a fiscal year to a calendar year.

ACTION:

It was voted to recommend to the House of Delegates that the HMA convert to a calendar year subject to the approval of the auditing firm.

The Finance Committee has explored the possibility of a real estate investment program in conjunction with all county societies and the Bureau of Medical Economics. The committee would like Council's approval to proceed with a real estate investment program.

ACTION:

It was voted that the Finance Committee proceed to explore a real estate investment program.

The Finance Committee recommends that Council approve an annual Christmas bonus for the HMA staff.

ACTION:

It was voted to approve an annual Christmas bonus for the HMA staff.

UNFINISHED BUSINESS

Status of the HMA Study on the Quality of Personal Medical Care: Dr. Mamiya reported that the Study is divided into four parts—(1) episode of illness, (2) office care, (3) cost of study, and (4) self-appraisal continuing medical education.

Episode of Illness: All the data has been collected—this includes the inhospital and ambulatory phase. The diagnoses were picked up from the hospital data and from the pre- and post-op data from the physician's office. The information has all been programmed, computerized, and will be ready for distribution.

Office Care: The data from this phase of the Study has been programmed and is ready to be fed into the computer; however, the information will not be ready for distribution for another couple of months.

Cost Study: This phase of the Study requires a separate project proposal and a grant application has been submitted which is a different method for funding from the rest of the Study. Information on funding for this phase is not known at this time.

Self-appraisal Continuing Medical Education: This phase relates to the episode of illness and can relate to the office care portion. This is the phase of the Study presently being initiated. The Hospital's Seminars are scheduled for February 12-19, 1971 at Makaha Inn. There are six hospitals included in the Study—four as experimental and two as control. Dr. Payne has received commitments from all hospitals to participate in these seminars. Each hospital has been asked and has agreed to share in the cost of the Seminars.

Policy Statements re Community Councils: It was reported that community councils and other projects (related to health) formed in the public interest to deal with matters such as drug abuse, health careers day, etc. will be necessary from time to time. The HMA should take the leadership in their creation, policy formation, and operation. Two methods of approaching the creation and operation of these councils were proposed:

1. The first, and most desirable, is to create them within and as a part of the HMA and every effort should be made to accomplish this. Should insufficient funds and/or personnel be available through the regular resources of the HMA, the HMA should set up projects and through the solicitation of private or public funds, seek to become the operating body as the grantee. The participation of other appropriate groups is to be encouraged.

2. The second, and less desirable, is in those instances wherein the HMA finds it impossible to create and operate projects of its own, the HMA may create or aid in the development of Community Councils to operate outside of the HMA's sole jurisdiction. In the development and operation of such councils the HMA should exert leadership in their formation and, regarding medical matters, direct the thinking of such councils. Furthermore, to insure their sound existence, the HMA should see to it that there be assessments of all organizational members and/or such financial assistance from foundations, government, the Chamber of Commerce, or other agencies that may be necessary in order that adequate financing and staff are provided.

ACTION:

It was voted to appprove the Policy Statement re the Formation of Councils.

Report on Malpractice Insurance: Mr. Thorson reported that the HMA Malpractice Insurance Committee will be meeting with representatives from Continental National Assurance Company (subsidiary to Continental Casualty) on December 17, 1970. Mr. Scheuber who will be representing the AMA and who did research on the malpractice insurance problem for the AMA will also be in attendance. The CNA's proposal will be to attempt to have a participating program with San Diego. A more in-depth report will be made after this meeting takes place.

Status of the Temporary Disability Insurance Program: The HMA-sponsored Temporary Disability Insurance Program will be continued for the year 1971. Premiums will be paid on an annual basis and only those people with premiums ranging from $800.00 will be allowed to pay on a quarterly basis. This change will eliminate some of the staff time in handling the program.

Report of the Hawaii Medical Library, Inc.: The report was again reviewed and discussed. The chairman of the Medical Education Committee was present to discuss the report and to answer any questions arising from the report.

NEW BUSINESS

Status of HMA's representative to the RMP Executive Committee: At the April 23, 1969, Council Meeting, it was voted that the HMA nominate the President-Elect of HMA to the Executive Committee of the RMP each year. Dr. Lowrey was appointed at that time and is serving a three-year appointment. The Council was asked to consider the appointment.

ACTION:

It was voted that Dr. Lowrey continue to fulfill his three-year term as HMA's representative to the Executive Committee of RMP.

Report of Dr. Edward O'Rourke's Proposal: Dr. Edward O'Rourke, Dean of the School of Public Health at the University of Hawaii, submitted Draft No. 3 of "A Proposed Hawaii Research and Development Program for Improved Health Services. The proposal included the need, health financing, why Hawaii is being selected, the extent of the problem, what the study would include, development of a program with advocate policy direction, and initial steps to be taken. Dr. O'Rourke writes "in summary, the broad goal of the projected research and development program is to determine mechanisms which can increase accessibility to health services within acceptable limits of costs and quality. This goal will be achieved by a program of research, analysis and testing and should be followed by a later period of implementation. The study results which reveal arrangements that achieve economies of operation; improved continuity of patient care, more comprehensive services; more rationally constructed facilities, better methods of educating health personnel, technological aids for patient care, alternative methods of financing care, and improved data systems for more efficient management, can serve as guidelines for future health delivery systems both in Hawaii and throughout the nation." There was considerable discussion on the subject and it was the general consensus of the Council that a letter be written to Dr. Paul J. Sanazaro, Director, National Center for Health Services Research and Development, requesting a meeting with him and to point out that the material from the study done by Dr. Payne should be completely analyzed before other activities in this area are undertaken.

ACTION:

It was voted to write a letter to Dr. Sanazaro expressing the HMA's concern regarding the proposal submitted by Dr. Edward O'Rourke.

The Council instructed Dr. Lowrey to meet with Gov. Burns to discuss the origin of the proposal.

Report of the AMA Delegate: Dr. Mills reported that the AMA President, Dr. Bornemeier, emphasized that the AMA must take a leadership role in the development of neighborhood medical clinics. Dr. Bornemeier said AMA leadership is vital so that physicians may insure that medical clinics remain a part of private practice. Some of Dr. Bornemeier's proposals include—(1) creation of a program to assist physicians in setting up adequate health facilities for group or solo practice; (2) seek a means whereby young physicians can be well advised and local medical societies will be involved in organizing and maintaining control of medical clinics; (3) as the concept of charity medicine fades while insurance plans grow, inducements to doctors to establish private practice groups in the ghettos should be considered, such as low cost federal loans or Hill-Burton type grants; (4) that the methods of training specialists be reviewed to emphasize ambulatory patient care rather than inhospital care, and that new MD's train at the side of experienced physicians in preceptorship programs; (5) that physicians concern themselves with plans to bring a substantial portion of the graduate training programs back under the control of the practicing physician, instead of the present tendency to shift supervision to employees of the hospital administration.

Dr. Mills reported that the House of Delegates of the AMA considered several reports and resolutions. The House had a lengthy debate on abortion. They rejected attempts to change the policy statement adopted at the 1970 annual convention and reaffirmed that policy. The House created a new class of membership for interns and residents. The House also approved revision of the Bylaws to provide for a direct membership category, with payment of AMA membership dues by doctors in the Veterans Administration, non-uniformed physicians of the PHS and other fulltime civilian physicians employed by federal agencies, who are ineligible for membership in a component medical society.

The House reaffirmed its approval of Peer Review Organization, as contained in the AMA Medicredit program, and urged that all components of organized medicine give energetic support to furthering the effective implementation of peer review. The AMA had objected to the provisions, among which were: (1) pre-admission approval requirements; (2) national norms of care; (3) federal ownership of professional standards review organization files; and (4) a $5,000 fine for violations, and review of all services provided. However, the Senate committee announced that it had (1) deleted the requirement of federal ownership of files, (2) deleted the $5,000 fine but retained provisions for refunds of fees, (3) eliminated national norms but retained provisions for regional norms, and (4) eliminated the necessity of preadmission approval for all elective procedures but allowing the PSRO to specify those situations where preadmission would be required. The committee report also specified that the PSRO could not be a medical society, but could be organized and set up by a medical society, such as a foundation.

The Delegates reaffirmed emphatically the age old professional ideal of medical service to all, whether able to pay or not. They not only adopted the report but urged wide dissemination of it to component and constituent medical societies.

In regard to health occupations, the terms "ancillary and paramedical" will be replaced by the term "allied." The Delegates approved the report dealing with licensure of health occupations. The recommendations in that report include (1) that State legislatures be urged to amend state medical practice acts to remove any barriers to increased delegation of tasks to allied personnel by physicians, (2) that alternative routes to licensure, such as job performance tests be studied, (3) that programs for periodically updating knowledge and skills of currently licensed or certified occupations be encouraged, and (4) that the House call for a nationwide moratorium on licensure of any additional health occupations.

The AMA House of Delegates approved Honolulu as site of the 1975 clinical convention. Dr. Mills reported that the AMA will be sending site visitors to Honolulu in about six to eight weeks to explore the existing facilities.

The Delegates gave strong support to the SAMA-MECO Project as an adjunct to undergraduate medical education, and asked constituent medical societies to consider supporting the project in their states. The full name is the Student American Medical Association Project for Medical Education and Community Orientation.

The Delegates approved the report calling on constituent associations to seek appropriate remedial state

continued page 60

Quotable Quotes

We were discussing the intellectual endeavors of wives and our homespun philosopher **Tom Thorson** came up with: "It's better to have a stupid wife who is aggressive than an intellectual one who is acquiescent."

At a Kuakini Executive Committee meeting, the discussion revolved around a certain doctor's chart which had been bounced back and forth between the Tissue, the Surgical, and the Medical Audit committees without action being taken. Our humorist **Ed Childs** remarked, "This reminds me of the Australian aborigine who wanted to buy a new boomerang, but couldn't get rid of the old one because it kept coming back. . . ."

Personal Glimpses

As executive secretary of the medical association, **Tom Thorson** apparently gets many kooky calls. "This young innocent thing called and asked, 'Do you need a premarital exam for premarital sex?' so I informed her that she needed the premarital exam for postmarital sex."

We were discussing the findings on the chest x-rays and tomograms on a husky Hawaiian man with a LUL lesion. Radiologist **Ed Childs** kept referring to the patient as "she," so we kept correcting him about the patient's gender, whereupon Ed explained, "x-rays are sexless to me except when I see a pelvic film. . . ." Apparently he refers to all x-rays in the feminine gender. . . .

We feel the immigration of English endocrinologist **Fred Greenwood** to the Islands has resulted not only in a "brain drain," but in a "humor drain" for Britannia. . . . Commenting on metastatic breast Ca, Fred points out that when there are high androgen and low corticosteroid levels, adrenalectomy and hypophysectomy result in a 55% success rate, but in a piddling 10% success when the reverse is true. "Therefore these blokes should go directly into chemotherapy. . . . We start with hope and end with despair. . . . The 'burn boys' do not cure, but by God, they die happier."

At a recent reception at the Imperial Room, Kaimana Hotel, cosponsored by the **Abe Kagan's** and **Grant Stemmerman's,** for the ABCC boys from Hiroshima and the researchers from California and our Honolulu Heart Program, we learned that Fred, with mustache bristling and a glass of bourbon in each hand, was overheard saying: "It has been statistically proven that all men who drink plain water eventually die. . . ."

Another of **Catalino Cachero's** 19th Hole Repertoire:

Two golfers caught up with a slow playing women twosome. Observed one of the golfers: "I had better hide. . . . That's my wife playing golf with my mistress. . . ." Whispered the other, also ducking behind some shrubbery: "What a coincidence! Mine, too!"

Dialogue from a Kuakini Oncology Conference:

Gynecologist **Harry Nakata** described how he was treating a 63-year-old woman with Stage I-C epidermoid Ca of the cervix with radiation instead of surgery because of the lesser morbidity. General surgeon **Yutaka Yoshida,** who takes unkindly to any form of treatment other than surgery, remarked, "Why not surgery? You fellows seem to take out myomas at the drop of a hat?"

A 43-year-old man with epidermoid Ca was found on exploration to have hilar as well as vascular metastasis. Pathologist **Grant Stemmerman** asked: "I would like to know what to do for this patient?" Retorted philosopher-surgeon **Walt Chang:** "You have to understand the philosophy of surgery. . . . It's like marching around the periphery of a bottle." Stemmy offered, "There is an effective drug, Bleomycin, in Japan." Walt Chang: "To embark on chemotherapy would be irrational. I am not against chemotherapy, you understand, like I'm not against motherhood and radiation. . . . He is on homeopathic doses of antibiotics, but I think we'll settle for radiation therapy. . . ." Interceded moderator **Noboru Oishi:** "You are right. . . . Consideration of chemotherapy is purely experimental. . . . Depends on your philosophy. . . ." (Pre-Ansfield era.)

Workmen's Compensation Hearing Of December 3

As is our usual practice with the daily flood of mail, we promptly cast some HMA material on a proposed Workmen's Compensation Schedule into that ever growing pile of "To-be-read-later-more-leisurely material." So when committee secretary Becky Kendro asked us if we were ready to testify at a hearing, we professed ignorance, and when the hearing was to be on our inviolate Thursday afternoon off, we naturally begged off. But Becky, we discovered, has remarkable persuasive powers, and when she expressed teary concern that there weren't enough physicians to testify, we succumbed. So on a beautiful Thursday afternoon, while our golf compadres were swatting away their cholesterol levels, we sat glumly in a hearing held in our smutty Mabel Smyth Auditorium. There on the stage sat Robert Hasegawa, Director of Labor and Industrial Relations, Maurice Silver, the Workmen's Compensation medical director, and several others of Hasegawa's staff gathered around a conference table, constantly transmitting memos back and forth and holding whispered huddles. The whole shebang was like a well-rehearsed quiz program, while the audience, consisting of the few testifying physicians and many representatives from various insurance companies, looked on bemusedly. . . .

We were impressed with this fellow Robert Hasegawa, a small-statured, boyish-looking, very fluent former labor leader, who has a keen perceptive mind and a subtle sense of humor, and who knew his facts. Herein are some of his commentaries: "I'm required by law to print a fee schedule with a specified fee. . . ." Time and again, he questioned, "I'm supposed to find what is prevailing, and if I find this, are you willing to accept it?" Then, again, he would remark, "I'm in a quandary. . . . I thought I would find acquiescence among you. . . ." Before a short recess, he said, "Let's take a short break. . . . Perhaps we can wring out a kidney or two."

Some of the pertinent items included the definition of a specialist vs. a nonspecialist; the discrepancy in that participating members of the Honolulu Foundation Plan accepted set fees there, but not with Medicare and HMSA; that physicians' conversion factors ranged from 4 to 9; and that most physicians used the RVS schedule. Perhaps the most important fact brought out by the various testimonies was that most physicians have a "usual and customary" fee which varies according to specialty, the amount of training, the locale of practice, and whether they are in solo or group practice. Everyone agreed that the existing Workmen's Compensation Schedule was completely outdated and that most physicians were reluctant to accept industrial accident cases. When we learned later that Al Yuen of HMSA had also testified in favor of a usual and customary fee, we were grateful. . . .

Members Speak Up

It appears that ecology minded **Fred Reppun** is on an anti-defoliant kick. . . . Fred feels that the use of defoliant is "a man-made blight along scenic roadsides. . . . Not only is this pollution in the worst sense, but it is government-made and government-sanctioned. The State, as much as the various counties, including our own in Honolulu, is flaunting pollution in our faces while politicians vie for votes by promising antipollution. Not only does weed killer applied to the roadside make an ugly burn, it also reveals what nature so generously and patiently hides through its lavish green growth—the mass

of litter that has accumulated. . . ." Nostalgic for bygone days, Fred says, "The answer is in road gangs (remedy for unemployment) that will weed instead of sickle. We used to see these friendly guys wave as we passed by; where are they now?" Fred also points out that the defoliants may run off into the seashore, killing fish and seaweed.

A "Local Physician" was referring to an article entitled "Big Island Hippies Brief Police" in which a Kona youth was quoted regarding the death of a 17-year-old: "I don't think he had to die. If police and hospital personnel can learn more about drugs, maybe that won't happen." Our physician writes, "We physicians who must cover emergency rooms do see these unfortunate victims of drug overdosage and we are obligated to treat them, usually without knowing the identity of the drug involved, since the patient is unconscious, incoherent, or hallucinating, and his 'friends' are unwilling or unable to provide the information. . . . It is not particularly pleasant to treat these unemployed, uninsured, and unwashed individuals while they mouth the worst kind of obscenities to the nurses. But we do treat them, of course—always hoping that someday we will get one who will learn that he must take some responsibility for his actions. . . . In the meantime, I sincerely hope that the public has not been led to believe that medical personnel should be educated on drugs by 'hippies'."

Hamilton Anderson from Maui wrote to the *Maui News*, "As you know, we are still getting dirty water in our taps (from open ditches carrying water) every time it rains in the mountains on the West Side. Our physicians see many more patients with diarrhea every time we have a flow of dirty water in our taps. . . . Our problems continue, but with the full support of the medical profession, we trust that officials responsible will come forward with a constructive answer to our continuing problems."

Stephen Tenby, in a letter to the editor entitled (by the editor) "No Repitition" (sic) was critical of a *Star-Bulletin* editorial recommending that Israel withdraw from Arab territories prior to any negotiation. Stephen bristled, "What you are suggesting is that Israel voluntarily withdraw from a position which is easily defended and which was fought and won with skill and lives being sacrificed. In return for this, there is a vague promise that Egypt may negotiate and that these negotiations might possibly end with Egypt recognizing that Israel exists. However, so far as the Israelis are concerned these negotiations might end with Egypt deciding that Israel should not exist, in which case we are back in 1957 once again. . . . I am sure that Israel is going to stay sitting on the Suez Canal until either she does cease to exist, or she is recognized as a sovereign independent state within secure and recognized boundaries, and a peace treaty has been signed between her and all the belligerent Arab states that surround her. To do otherwise would I am sure, for Israel, be suicide."

Charley Brown, who practices in Waikiki, complained to the City Council that the ordinance clamping down on sidewalk soliciting is doing no good and that "there are just as many solicitors as before. . . . The Krishna group is wearing out the sidewalks pumping up and down—and passing an offering bowl to most passersby—others have various cards—either a magazine- or pots-and-pans-selling gambit. Waikiki becomes 'cheaper' and more tawdry day by day."

We received a good jolt from our uninhibited **John Brown,** who wrote in his column "Inside HMA."

re public relations: "Our public image is not good and getting worse. . . . It's time physicians stopped treating themselves and called for expert help—someone with the ability and guts to tell us what is wrong and what we need to do to change."

re water safety and the shark problem: The answer is to return to catching sharks as a game fish and eating them. The old Hawaiians relished shark meat. It is an excellent food. Haole prejudice stopped that, and it is high time we did what we could to overturn that ridiculous nonsense."

re the high percentage of new active TB cases among foreign born persons: Are you aware that in countries abroad, there is a black market in x-rays?

re the Woman's Auxiliary Committee: It is one we could do without. The only meeting it held in the last year was a discussion of whether it should be abolished. It decided not to commit suicide, which is an understandable error."

Women's Lib Front

Dynamic, politically minded **Cora Manayan** recalls that it took a private bill introduced into Congress by Sen. Hubert Humphrey and Rep. Eugene McCarthy to gain her citizenship. She feels that other Filipino women with less opportunity may be letting U.S. citizenship slide by them, and worries that many of her former countrywomen, who have emigrated from the Philippines, arrive here with dreams of a new life; dreams that aren't coming true for them or for their families. "I don't know where to begin to help my people, but the more I thought about the problem the more I knew that we Filipino women couldn't do anything unless we got active in politics." So she organized the Filipino Women's Political League, founded October 1, and became its first president. Her other concerns are the children of Philippine immigrants who enter the Hawaii State school system with little or no knowledge of English and the care of elderly Filipinos. Commenting on a *Star-Bulletin* report that "lonely Filipinos are dying like dogs in Kona" she acknowledges, "It may be the fault of our people, that they are too proud to accept the fact that they are beggars. Do they know about Social Security, do they know what rights they have?" Cora concludes, "Our essential goal is that every Filipino woman should be a good American citizen and not a liability to her community."

Anti–Women's Lib Front

Perhaps we can all learn from our personable **Carolina Dizon Wong,** physician and mother, who is chief of staff at SFH and part-time physician at the U of H, and who has a part-time private practice. . . . She recalls how when she first went into private practice, she would "see the patients, go into the anteroom and stir the stew, home to check the children, back to the office to stir the stew and see the patients, and home to serve the stew." Regarding her role as Chief of Staff, she comments, "It's really some work! Doctors and staff members are no different from other people. There are always some personal and petty differences to deal with before you can get to solving the real problems. I just always hope I can mediate." We learned that her family life centers around the dinner table. "First we eat, then we talk about chores for the children and about our problems. Somehow, we've always kept an up-and-going feeling in our family. We don't seem to have trouble communicating. I don't know why there should be any gap. We tell the children to be good. Maybe that's old-fashioned, but we think it makes a lot of difference." Regarding sex, Carolina says, "Society seems to make it not important anymore. If young people just go from one person to the next, some of the feeling is lost. . . . Then marriage no longer is anything to look forward to. There's no one really to belong to and some of the finesse of life is lost." She muses, "Someday, though, I want to take up knitting again. When you knit, you can think at the same time."

Notes From The Aetna Medicare Review Meetings . . .

A 72-year-old man with orbital phimosis resulting from enucleation of his left eye had an orbital graft, using his prepuce, when the standard graft procedure had failed.

Practical **Lup Pang** noted, "Well, he didn't charge for the circumcision. . . ." Jokester **Ted Tseu** observed, "Now everytime a pretty girl goes by, his eye will pop open." (We later consulted **Vernon Jim** who offered the information that odor was one of the objections to use of preputial grafts, but then who cares when we can get an erectile orbit. . . .)

Our perennial comedian **Bernard Fong** started to say, "This is a really scr . . ." and caught himself in time to say, "I mean, fouled up case. . . ." A dermatologist had treated a patient 19 times with everything under the sun and concluded his explanatory letter with the statement, "Never before have I ever had a more difficult case." Bernie was in sympathy, but felt that Aetna should pay for the office visits, the initial shot of cortisone and the final punch biopsy. Whereupon **Vic Hay-Roe** said, "If everything else fails, we *should* make the diagnosis."

A case with multiple physicians involved was reviewed and again the problem was who to pay. Astute **Vic Hay-Roe** remarked, "I learned that the best thing is to get your bill in first. . . ."

A 106-year-old woman had hemorrhage from her tongue. **Bernie Fong** said skeptically, "I don't believe it (referring to her age), but Aetna should pay for the chest x-ray and EKG, and deny the cholesterol, uric acid, and alkaline phosphatase charges. . . ." (His contention being that these lab values did not mean much at her age. . . .)

Retraction

When **Doris Jasinski** showed us a statement from the Hawaii Pathologist Lab giving Cas a credit of $1.235.70 for two tissue specimens, we wrote that they were extra precious hemorrhoidal tissues, but Doris recently cornered us and demanded a retraction for misinformation; that it was really disc material rather than hemorrhoidal tissue, so here goes: "Dear Doris: Sorry for the error—guess it was that pained expression on Cas' face as he sat down during the Friday morning conference that made us draw such a hasty conclusion. But even for that amount of money, we really don't think you should get *either* your hemorrhoids or discs out.... Yours truly...." (Besides, proctologists **Dick Omura** and **Clarence Sakai** have been using the relatively painless ligation technique. Clarence especially has been after ours for several years now and we're still procrastinating. . . .)

Sportsmen

Modest **Lindy Chun** confessed to us in private during a Children's luncheon conference that he had made a hole-in-one in October on the MidPac 11th hole with a 4 iron. . . . On November 21, the first day of the Annual Hawaii Pathologist Association Golf Tournament, **Ed Izawa** swung his favorite 5 iron in a classic Izawa square-to-square swing at the Makaha West Course 127-yd. 9th hole. The ball took a high curvilinear path over the pond, headed straight for the pin located on the upper tier, and seemed to land fairly close to the pin. Ed's partner, **Hide Oshiro,** was all smiles, but **Mike Okihiro** and we had just pushed the best ball and we were crushed. Oh well, we can still tie by sinking one of our 30- and 40-foot putts, we thought. But then gloom turned to despair, for the closer we approached the green, the closer the ball got to the pin. In fact, it was leaning against the pin! Then we rejoiced and we could hear Ed moaning happily, "Oh no! Oh no! Not here!" We cheered even more when we learned that Ed was a member of "The Hole-In-One Club" ($10.00 per annum dues) which entitles one up to $200 of refreshments plus a ten-day vacation for two in Europe (London, Paris, Rome) or to Bermuda or on a Caribbean cruise. We celebrated with a $17.00 bottle of Makaha Inn's finest champagne and Ed happily footed the $170.00 bill for refreshments that evening including after dinner wine for the entire Pathologists Association banquet which was gratefully acknowledged by both president-elect **Meryl Haber** and outgoing president **Larry McCarthy.** The Golf Tournament, incidentally, was won by tournament chairman **Frank Fukunaga,** 2nd place by **Hideo Oshiro** and 3rd place by **Coolidge Wakai.** . . .

During a pre-Christmas evening of cocktails at **Ed Izawa's,** the discussion centered on the relative incidence of holes-in-one. **Mike Okihiro** reported that the chance of a hole-in-one was once every 17,400 strokes. Skeptic **Don Maruyama,** whose game has taken an anticipated turn for the worse since his cervical spine surgery, was disenchanted about his own chances until we pointed out that even we had a hole-in-one back in 1960, using a 3 wood on the Ala Wai 3rd hole, and that **Tom Oshiro,** with less than 6 months of play, had made a hole-in-one on the same hole using a driver. Statistically-minded **Frank Fukunaga** pointed out that even if we paid 10 dollars a year for the next 30 years (assuming of course that the dues do not rise), we would still be ahead of the game should we make a hole-in-one. Those interested should write: "The Hole-In-One Club." 45 Rockefeller Plaza, New York, N.Y. 10020. Should the Club bankrupt or fail to pay out, **Ike Nadamoto** promises to stand good the expenses. . . .

The John Takamura Invitational, consisting of eight select foursomes, was held in November at MidPac and traditional grand slam winner **Bill Dang** won with a 90-24-66, **Bozo Chun** was 2nd with 78-8-70 and **Coolidge Wakai** 3rd. **Lup Pang,** who had participated, refused to divulge his score, and grunted tersely, "Tough course. . . ." There are some who question the veracity of the computer which tabulates **Bill Dang's** MidPac handicap, but we in the know realize that Bill has a simple formula for winning tournaments. He merely plays every day for the whole week preceding any tournament and quite naturally shoots better than the computerized handicap which takes a month to catch up. That's all. . . .

Doctors in Print

The Achilles Reflex Thyroid Function Test: Evaluation of A New Instrument; Amer J Med Sci, V. 259, pp. 419-423, June, 1970. Robert A. Nordyke, M.D., and Fred I. Gilbert, Jr., M.D.

Announcements

The *1970 Hawaii Relative Value Studies* is now available in the Hawaii Medical Association office. One copy will be provided free to each member of the HMA. Additional copies are $10.00 per copy. Copies are available for non-HMA members at $10.00 per copy. The effective date for use of the new *RVS* will be March 1, 1971.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The Nineteenth Annual Clinical Meeting of The American College of Obstetricians and Gynecologists will be held in San Francisco, May 3-6, 1971.

The program will develop three themes, Perinatology, Pelvic Infections, and Diseases of the Vulva, one each day. The general sessions, seminars, correlated seminars, round tables and reports on clinical investigations will each relate to the day's theme.

Non-Fellows may register to attend both the meeting and the Postgraduate Courses which precede the meeting on May 1 and 2.

Contact: Donald F. Richardson, 79 West Monroe Street, Chicago, Illinois 60603.

continued page 60

RICHARD HO PING SIA, M.D.
1895-1970

Richard Ho Ping Sia was born in Amoy, China, on April 28, 1895, the son of Kee Phin and Cheng long (Tan) Sia. He spent his early life in this small fishing village in South China and in 1910 entered Boone University in Wuchang, a missionary college. He graduated in 1914 with a B.S. degree.

At 19 years of age, he left China to study medicine at Western Reserve University School of Medicine. To sustain himself during his medical school years, he worked part time as a waiter in a Chinese restaurant and later found work as a laboratory assistant to Dr. Harold Cole in the department of dermatology and syphilology. In 1918, at 23 years of age, he received his medical degree. This was followed by a year's general rotating internship at the Cleveland City Hospital.

Dr. Sia then returned to China and settled at Peking Union Medical College as an Assistant in Medicine.

Early in 1921 he published a paper in *The Chinese Medical Journal* in collaboration with biochemist Wu Hsien (of Folin-Wu fame) on the detection of kala-azar, by a procedure which became known as Sia's test, which consisted of adding one drop of serum to demineralized water in a test tube, with precipitation or flocculation indicating a positive reaction. This euglobulin test was perhaps the first screening test for primary macroglobulinemia, as recommended by Waldenstrom.

In 1923 Dr. Sia was accepted to the Rockefeller Institute for Medical Research in New York City as a research fellow, for a year, in bacteriology.

He returned to New York in 1929 for another year, this time working with M. H. Dawson at Columbia on the biology of the pneumococcus.

In early 1930's, Dr. Sia became director of contagious diseases at the Peking Medical Center. He advanced to Assistant Professor of Medicine in 1930 and to Associate Professor of Medicine in 1934.

In 1923, during his fellowship year at the Rockefeller Institute, Dr. Sia met and married Mary L. S. Li, who was doing postgraduate work in music at Yale University. Mary, from Hawaii, had never been to China. Her parents, Dr. Khai Fai Li and Dr Tai Heong Kong, were the first married couple of Chinese ancestry to practice Western medicine in Honolulu. Later, Mrs. Sia was to become known as an expert on Chinese cuisine. Following Dr. Sia's fellowship year, the Sias returned to China. They subsequently became the parents of a daughter, Sylvia Chia Yu (Mrs. Donald H. Tsai), Calvin Chia Jung, now a practicing pediatrician, and Julia Chia Fen (Mrs. Sheridan C. F. Ing).

With the outbreak of the Sino-Japanese War in 1939, Dr. Sia, fearing for the safety of his family, moved to Honolulu and accepted a visiting professorship in bacteriology at the University of Hawaii. Beginning a new career at the age of 44, he served on the staff of the University for seven years as a lecturer in bacteriology and as the health physician in initiating a college health services program there. Dr. Sia became a naturalized U.S. citizen in 1945.

In 1946 he left the University faculty to devote himself to private practice. He was to spend the next twenty years in this new career as a family physician. He developed an active solo practice, dedicating himself to the service of his patients. He was on the active staff at St. Francis, Queen's, Children's and Kapiolani Maternity Hospitals. In 1969 he retired, culminating an interesting medical career of basic research, clinical teaching and private practice.

During his years in China he was a member of the Chinese Medical Association, the Chinese Society of Microbiology and Pathology, serving as Secretary in 1930-1931, and the Peking Rotary Club, Secretary 1935-1936. He was also a member of the Society for Experimental Biology and Medicine, New York (member of the council 1938-1939), the Hawaiian Academy of Science, the American Association for the Advancement of Science, the American Medical Association, the Hawaii Medical Association, and the Honolulu County Medical Society. He was a Shriner and a Mason: Master, International Lodge, Peking, 1931; Master, Lodge of Perfection, Peking, 1932; a charter member of Waikiki Lodge No. 774; and a member of Aloha Temple, Honolulu. In 1969 he received the coveted 33rd degree in Masonry.

The doctor had a special interest in music. While in college at Boone University, Wuchang, China, he directed the orchestra for four years. In Peking, he was choir director of the Peking Union Medical College choir for twelve years. He sang at Dr. Sun Yat Sen's funeral. On coming to Honolulu, he was director of the choir of the First Chinese Church of Hawaii for several years and also served on the Board of Deacons. Later he joined Central Union Church and served on the Board of Deacons. Mrs. Sia, an organist, participated actively with him in these areas.

In addition, he enjoyed his tennis and fishing. The Sias were mixed doubles champions at the summer resort Peitahou, China, for many summers in the 1930's, and Dr. Sia continued to play three times a week until only a few years prior to his death.

Dr. Sia died in Honolulu, May 23, 1970, at the age of 75. He will long be remembered for his honesty, humility, and sincere dedication to service of mankind. He was an outstanding example of the successful combination of academics and private practice in medicine, and a reflection of the blend of the East and West.

CALVIN C. J. SIA, M.D.

How professional can you get?

Hawaii's largest life insurance company offering the lowest rate on TDI for employees of professionals. And to top it off, we will also cover non-incorporated professional persons at the same rate! It's not too late to switch. Call us today!

Phone 537-4902, Ext. 143



Hawaiian Life INSURANCE CO., LTD.

Hawaii's first and largest life insurance company
Home offices: Kapiolani Blvd. at Piikoi St.

it's the real thing

Enjoy Coca-Cola Trade-mark ®

COCA–COLA BOTTLING COMPANY
OF HONOLULU, INC.

Notes & News *continued from 58*

New Product

S.O.S. is now more than a Radiotelegraphic Distress Call—The SNUFFED OUT SYSTEM Smokers' guide breathes all sorts of analyses into smokers' problems and guarantees you'll quit smoking or your shortness of breath back!

The recently published handbook "SNUFFED OUT" periscopes the curious Oral Ritual of Self Pollution and offers a Doer's mixture of Psychological tools to stop smoking. Send $1.50 plus 35¢ for Postage and Handling to: SNUFFED OUT, Box 236 SS, South Elgin, Illinois 60177.

Slants and Angles *continued from 39*

Obviously such obesity becomes an anachronism in our present prosperous era, and most physicians rightly urge their overweight patients to reduce. However, by reducing could they perhaps be exchanging one problem for another? Some recent studies suggest that persons following diets low in cholesterol and saturated fats are more susceptible to carcinoma.

Plus ça change, plus c'est la même chose—the more things change, the more they are the same.

W. PHILIP JONES, M.D.

Hawaii Medical Ass'n *continued from 55*

legislation in the field of professional liability, and encouraged the Committee on Professional Liability to continue to explore all aspects of the professional liability problems.

Dr. Mills reported that Travel Consultants has requested a letter of support from the HMA to the AMA relative to Travel Consultants and Trade Wind Tours of Hawaii handling the travel and housing arrangements for the 1975 Clinical Session.

ACTION:

It was voted to write the AMA that the HMA has no objection to having one travel agent handle the travel and housing and that Travel Consultants be considered.

Report of the Woman's Auxiliary: A written report submitted by Mrs. Betty Lawson was circulated, and reviewed.

Miscellaneous: A brief report was presented on the Bennett amendment.

ADJOURNMENT

The meeting adjourned at 10:00 P.M.

R. VARIAN SLOAN, M.D.
Secretary

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

SK&F Co., Carolina, P.R. 00630
a subsidiary of Smith Kline & French Laboratories

natives for the past four years. He also showed some colored slides of the people in that area, their culture and some of the medical problems encountered.

* * *

The joint meeting with attorneys on November 10 was attended by approximately 200 members and guests.

New members introduced were Drs. Amelia Jacang, George H. Lewis, Eugene N. Wong and Stanley Hartroft.

Mr. Thorson announced that the Workmen's Compensation hearing originally scheduled for September has been set for December 3 and 4 in the Mabel Smyth Auditorium. A number of doctors will be receiving letters from the HMA asking them to appear at the hearing to present testimony as to whether or not they use the RVS, what conversion factor they use, and examples of fees to demonstrate how they use the conversion factor. He urged the doctors to attend if called upon.

It was announced that the Diabetes Drive which started November 9 is going strong and will continue through November 21.

Dr. Grover Batten informed the membership that the Hawaii Medical Library is conducting a fund drive to keep up with the rapidly expanding knowledge and to cover the increasing costs of operations. He stated that the main contributors to this drive will be trusts, foundations, corporations, lay donors, and physicians. Gifts from the doctors are particularly important since they will set the pace. A goal of $1,200,000 has been set. It is hoped that each physician will average $2,000 a year for a period of five years. He emphasized that gifts of $10, $20, and $50 will be accepted but will not do the job. He asked the doctors not to send gifts now. Each doctor will be contacted later. In conclusion Dr. Batten stated that it takes a lot of people working together to make up the team and that a successful drive will increase the Medical Library's services to the entire Pacific Basin.

A Medical-Legal Symposium was presented by a panel of physicians and lawyers. Members of the panel were Drs. Albert Chun Hoon, Thomas Frissell, William Natoli, Attorneys Edmund Burke, Wallace Fujiyama, and Paul Cronin. The panel discussed topics of interest to both professions: Medical Fees in Litigated Cases, Medical Reports, and should the County Medical Society furnish doctors to testify in court in medical malpractice cases. A question and answer session followed the discussion.

Dr. Varian Sloan presented the Nominating Committee's Slate of Nominations, copies of which had been circulated to the membership. The Nominating Committee felt it was not proper for any of the members of the committee to be nominated for any office, therefore, their names do not appear on the slate of nominations. Additional nominations from the floor were made as follows: Nominated for: President-Elect, Dr. Winfred Lee; Treasurer, Dr. Don Poulson; nominated to the Board of Governors were Drs. Robert Rose and Coolidge Wakai; Alternate Board of Governors, Drs. William Dung and Thomas Lau; Medical Practice Committee, Drs. Thomas Brown and John Kim; Nominating Committee, Dr. Fred Gilbert; Delegates to HMA, Drs. Kenneth Momeyer, Alexander Roth, Frederick Warshauer, Felix Lafferty and Shigeru Horio.

Dr. Carl Lum brought out that in the last County Society Bulletin there was a paragraph stating that the Board of Governors of the HCMS had approved the relocation of its offices to a new building at School and Liliha. Dr. Lum stated that the Board of Management of Mabel Smyth Building is concerned about the effect this move will have when the second floor is vacated. He referred to the 99-year lease held by Queen's Hospital of the property on which the Mabel Smyth Building is located, title to which is held by the Trustees of Bishop Museum (deed of trust dated May 1897). The deed provides that if the hospital faithfully observes and performs all of its obligations under the lease during the term of the lease, the Trustees of the Bishop Museum shall convey the property to the hospital at the expiration of the lease. The use and occupancy of the building is governed by the provisions of an agreement dated October 1939, entered into by the Hawaii Nurses Association, Hawaii Medical Association and the Queen's Hospital. The agreement states that this building shall be used as a medical center and that the joint associations agree to guarantee to meet all expenses necessary for the proper maintenance of this building. Dr. Lum stated that we cannot move without having some financial responsibility in this building. He further stated that if the second floor were vacated they could not rent out the second floor without the approval of the Board of Management, Queen's Hospital and Bishop Museum. He stated that it is the hope of the Board of Management that the County Society and HMA will remain in this building. He brought out that they have retained the services of an architect and it is feasible to add a second floor over the auditorium, giving approximately 3,000 sq. ft. of additional floor space. The estimated cost would be $125,000. Dr. Lum then stated that he would like to move that the officers of the Society or its designated representative (Site Committee) meet with the Board of Management of Mabel Smyth to discuss this business and that this business be brought before the general membership prior to any firm commitment to relocate to another building. The motion was seconded.

In the ensuing discussion it was brought out that the Peat, Marwick, Mitchell report recommended very strongly the consolidation of the offices and staff of the HCMS, HMA and BME into one facility, and that the Site Committee was appointed to implement this recommendation. It was mentioned that no commitments can be made until the Council of HMA meets on December 11 at which time this matter will be brought up.

Following the discussion, the motion made by Dr. Lum was voted on and was passed by the membership.

A motion to congratulate Dr. George Mills on his election as senator to the State Legislature was unanimously passed by the membership.

Maui

Members present at the September 15 meeting included: Drs. Sowers, Romero, Moran, Morris, Underwood, Pfaeltzer, Achong, Iaconetti, Uehara, Fu, McCollum, Dietrich, LaFon, Percy, Allred, Tofukuji, Burden and Wong. Also present were: Drs. Briley and Kepler.

The application of Dr. John Briley was acted upon and passed favorably by unanimous vote by the members present.

The Family Planning Clinic plan was then discussed by Dr. Allred and Dr. Uehara. A discussion followed. Dr. Iaconetti then moved that the patients be referred to private medical doctors for family planning techniques instead of accepting the proposal of such a clinic. The motion was seconded and passed.

Dr. Pfaeltzer then introduced Dr. William Kepler to the Medical Society.

A general outline of the prepaid medical plan to be offered on the Maui County Medical Society basis was then circulated by Dr. Uehara. It was felt to be competitive with Plans I and II of Kaiser or Plan IV of HMSA and that this plan would involve the Maui physicians and still yet offer a free choice of physicians. The offers by medical insurance carriers have not been received as of yet. A definite decision regarding this matter will be considered in the next meeting.

Dr. A. Y. Wong then presented the summary of the two previous Diabetic Screening programs and it was noted that Drs. Wong, Uehara, Sowers and Percy would continue to be on this committee and that Dr. Percy would be co-chairman of this committee.

The Workmen's Compensation hearing which was to be held September 21, 1970 was reported to be postponed.

Through the HMA Council meeting to be held this Friday, Dr. Iaconetti is to request for further elarifieation on a previous HMA Council meeting regarding prepayment prineiples as outlined in the previous meeting.

Dr. Sowers then presented a publie eardiosereening analyzer offered by the Hawaii Heart Assoeiation to be presented at the next Maui County Fair. It was moved, seeonded and approved to offer this eardiosereening teehnique.

Dr. Burden then requested that Utilization Committee of the Medieal Soeiety pay for their breakfast eharges. It was moved, seeonded and approved that further investigating regarding this situation take plaee.

* * *

Twenty members were present at the Oetober 20 meeting at the Landing in Kahului.

A eommunieation from HMSA was presented stating that they were not interested in the proposed prepayment plan at this time. In similar vein, the Hawaii Foundation earriers elaim that the plan eould not be eompletely assayed yet beeause the exaet number of the hotel employees and potential members to be eovered is not now known. It was also announed that the ILWU would be interested in an all-inelusive self-insured medieal plan of their own.

Dr. Longworth was introdueed as a new physieian, major speeialty in Ob-Gyn. with the Kaiser group, eoming from Fairfield County, Conneetieut. Sinee he is a transfer, no dues will be fortheoming.

A Nominating Committee of Dr. Underwood as ehairman, Dr. Aehong as member and one other member to be ehosen will present a slate of offieers at the next meeting in November.

Dr. Uehara suggested that the Soeiety send a letter of appreciation to Dr. Guthrie for his work in the reeent Shigella outbreak. It was moved by Dr. Morris and seeonded by Dr. Sowers that this be done and Dr. Uehara then read a prepared resolution. This was passed unanimously.

It was announeed that the Annual Meeting and Party will be held in Deeember and an additional assessment may be neeessary sinee no funds were available.

Dr. Strother announeed that there would be a Medieal Soeiety family pienie at Fleming's Beaeh from 9:00 A.M. to 5:00 P.M. on Sunday, October 25.

Dr. Uehara then read letters and abstraets prepared by the Bureau of Researeh and Planning. This was then followed by abstraets from Dr. Paine's prepared report. There was eonsiderable diseussion, partieularly about the point of peer review of offiee praetiee.

It was announeed that Dr. Moser would sueeeed Dr. Iaeonetti as Regional Medieal Program Maui representative in RAG. Also that on the Maui Eeonomie Opportunity Board, Dr. Sowers volunteered to sueeeed Dr. Uehara.

Dr. Moser proposed and it was seconded by Dr. Iaeonetti that some thought be given next year for a shorter business meeting and some type of scientifie meeting with a well-known speaker.

* * *

The meeting on November 17 was held at Heinz Restaurant.

Members present were: Drs. Uehara, Withers, Sowers, Strother, Burden, Izumi, LaFon, Morris, Iaeonetti, Romero, Dietrieh, Tofukuji, Moran and Underwood. Guests present were: Drs. Longworth and Dioso.

A letter was read from Governor Burns thanking the Medieal Soeiety for the letter of eommendation for Dr. Guthrie.

The Utilization Review report was read requesting an inerease of the eharges to the hospitals that are reviewed. The motion was passed to approve the inerease in the eharges to these hospitals.

The Christmas Party will be Saturday, Deeember 12, 1970 at the Maui Hilton Hotel.

Dr. Uehara reported on the HMA's efforts to work with Hawaii Insuranee & Guaranty eoneerning renewal of malpraetiee insuranee. Polieies will probably range from $500 to $2,600. It was suggested by Dr. Longworth that the Soeiety should have the legislature push for legislation requiring pretrial arbitration.

Dr. Uehara reported on the Council on prepayment plans whieh had met at Vietoria, B.C.

The revision in Workmen's Compensation was diseussed. At present they are eonsidering a eonversion of 6.0 with speeialists reeeiving 25% more. It was proposed that the president write a letter stating that the Maui County Medieal Soeiety favored working through HMA rather than the speeialty organizations.

The report of the prepayment plan by Cal-Western Life was given by Dr. Uehara. This ineluded life insuranee and dental eare. It was based on a eonversion of 6.0. Copies are to be left at Judy's desk and a sign-up sheet will be present for those physieians wishing to partieipate. The eommittee on prepayment plans will meet during the following week.

A letter was read from Dr. Burden requesting approval of the Medieal Soeiety for loeum tenens of residents from Tripler Army Hospital. This approval was given unanimously.

The applieation for membership of Dr. Edmund Longworth was passed unanimously.

Eleetion of offieers was held for the year 1971. The slate of offieers eleeted: President, Dr. Milton M. Howell; Vice President, Dr. Denis J. Fu; Seeretary-Treasurer, Dr. John N. Withers; Delegates, Dr. J. Mark B. Sowers, Dr. John F. Morris, Holdover; Alternates, Dr. Clifford F. Moran, Dr. A. Y. Wong, Holdover.

Dial

537-5353

for
the finest printing service
in the state

star-bulletin printing company

420 WARD AVENUE HONOLULU, HAWAII 96814

Efudex®
(fluorouracil)
cream/solution

In the treatment of solar/actinic keratoses-
An alternative to cold, fire and steel

2/23/68
Before treatment with 5% 5-FU cream. Patient R. G., 78 years old, shows extensive skin changes due to weathering and severe solar/actinic keratoses.

3/26/68
Following one month of therapy. Intense erythematous reaction is seen at sites of keratoses. Normal skin has not reacted. Some areas which had reacted initially have undergone healing despite continued topical application of 5% 5-FU.

6/11/68
Ten weeks after discontinuance of therapy. All areas have healed complete Residual mild erythema remains in som areas. This patient also had seborrheic keratoses which, as expected, have not reacted. There is no evidence of residua lesions or recurrences.



ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

n alternative
conventional therapy

Efudex (fluorouracil) offers the physician a ical alternative to cryosurgery, electrodesiccation l cold-knife surgery in the treatment of solar/actinic atoses. It is effective, comparatively inexpensive and ecially well suited for treatment of these multiple ons. Important, too, is the highly desirable cosmetic ult. Clinical experience demonstrates that treatment h Efudex results in an extremely low incidence of rring.*

lighly effective

In clinical trials, depending on the dosage form d strength used, complete involution occurred in to 88 per cent of lesions following treatment. The e of recurrence was low, ranging from 1.7 to 5.6 per nt up to a year after completion of therapy. When w lesions appeared, repeated courses of Efudex erapy proved effective.*

redictable
nerapeutic response

Two to four weeks constitutes a typical course Efudex therapy. The response is usually characteris- and predictable. After three or four days of treat- ent, erythema begins to appear in the area of keratoses. his is followed by an intense inflammatory response, aling and occasionally moderate tenderness or pain. he height of the inflammatory reaction generally occurs o weeks after the start of therapy, and then begins subside as treatment is stopped. Within two weeks of scontinuing medication, the inflammation is usually one. A mild erythema may remain for two or three onths before gradually receding. Since this response so predictable, lesions which do not respond hould be biopsied.

wo strengths—two
losage forms

Efudex is available as a 2% or 5% solution or a 5% cream. It is applied twice daily by the patient ith a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two im- ortant considerations: First, please consult the com- lete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



new
Efudex®
(fluorouracil)
cream/solution

*Data on file, Hoffmann - La Roche Inc., Nutley, New Jersey.

Call Us for
OPHTHALMIC INSTRUMENTS

OPTICAL DISPENSERS
of Hawaii, Inc.

1133 BISHOP STREET
HONOLULU, HAWAII — 537-6570

1441 KAPIOLANI BLVD., SUITE 312
HONOLULU, HAWAII — 949-4795

103 PROFESSIONAL CENTER BLDG.
30 AULIKE STREET
KAILUA, HAWAII — 261-6030

Complete Contact Lens Service Available

Equipment Distributors for:
BAUSCH & LOMB, AMERICAN OPTICAL CO., SHURON, TITMUS, RELIANCE, WELCH ALLYN, KEELER AND LAWTON INSTRUMENTS.
CARL ZEISS, INC.

MEDICAL PLACEMENT BUREAU and NURSES' REGISTRY

24 Hour Service

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

1415 Kalakaua Avenue **Suite 210**
Phone 949-1237

In Memoriam *continued from 44*

tice. He went immediately to Lahaina, Maui, to take over the practice of Dr. James Molony for four months.

Mrs. Burt and their daughter joined Dr. Burt in March, 1906, but remained on Maui while the doctor went to Pukoo, Molokai, for a few months. From Pukoo he seems to have gone to Waialua Plantation, Oahu, to substitute for Dr. Hubert Wood. Sometime in 1907 he returned to Maui to substitute for Dr. Wilbur McConkey of Paia and then for Dr. Bruno Sandow of Puunene.

When Dr. Molony resigned his post and left Maui in January, 1908, Dr. Burt became the government physician for Lahaina. He also served as physician for the Pioneer Mill Company and was in charge of the plantation hospital. By 1909 he had become Acting Assistant Surgeon of the U.S. Public Health and Marine Hospital Service for the port of Lahaina. Later he also served as doctor for the Olowalu Sugar Plantation and Mill.

With retirement in mind, Dr. Burt resigned his post as government physician in August, 1918. However, when his replacement failed to pass his territorial medical examination, Dr. Burt accepted reappointment for another year. In October, 1919, Dr. George Webb arrived in Lahaina, and Dr. Burt was able to retire and take an extended trip on the mainland.

He returned to Lahaina in October, 1920, but did not engage in practice. On December 9, 1921, Dr. Burt died at Lahaina at the age of 68.

He was a member of the Hawaii Medical Society and of the Buckeye Club.

Book Reviews *continued from 45*

nificant physical findings detected by percussion and auscultation, and other observations, are critically discussed and correlated with more sophisticated laboratory tests.

Although this text reflects the opinion of one clinician, his authoritative and persuasive illustration of the benefits of clinical diagnosis in cardiac disease must be applauded, since the computer has still not replaced the knowledgeable and precise clinician. It is recommended for all clinicians who have occasion to examine the heart.

WINFRED Y. LEE, M.D.

Pathology Annual, Vol. 5, 1970

Series Editor Sheldon C. Sommers, M.D., 436 pp., $15.00, Appleton-Century-Crafts, New York.

THIS IS the most recent volume of the relatively new series of pathology papers covering a variety of subjects. As in the previous editions, the format consists of about sixteen titles primarily concerned with anatomic pathology. The subject matter in this particular issue includes, among others: embryonal carcinoma of the testis, primary carcinoma of the liver, tissue culture of human tumors, and Pneumocystis carinii pneumonia, as well as such topics as the hospital tumor registry and the use of polarized light in pathology. The papers summarize current knowledge, both practical and experi-

mental, concerning each subject, and a list of references is presented at the end of each chapter. Although the series is obviously oriented to the pathologist, selected papers dealing with lesions even within a clinician's field of practice would be of interest to nonpathologists as well. For the most part the papers are clear and relatively concise.

Gross photographs and photomicrographs, though limited to black and white, are of very good quality.

This series is recommended to pathologists for their personal libraries and should be of value as supplemental library reading for clinicians, particularly those in the surgical specialties.

ANN B. CATTS, M.D.

The Current Status of Liquid Scintillation Counting

By Edwin D. Bransome, Jr., M.D., 394 pp., $19.75, Grune & Stratton, 1970.

A HIGHLY TECHNICAL but complete reference source on the current status of this subject which appears to be an important contribution to basic scientists and clinicians. This text is based on an international symposium and is recommended for those with special interest in this field.

WINFRED LEE, M.D.

Also Received

Handbook of Legal Medicine

By Alan R. Moritz, M.D., and R. Crawford Morris, LL.B., 238 pp., $8.75, C. V. Mosby, 1970.

THIS COMPREHENSIVE and concise handbook is an excellent guide for those that desire information in this increasingly important subject.

Spectroscopic Approaches to Biomolecular Conformation

By D. W. Urry, 314 pp., $15.00, American Medical Association, 1970.

A HIGHLY technical and comprehensive text on this basic science subject which is an outgrowth of a symposium held in 1969 at the Great Lakes Regional Meeting of the American Chemical Society.

Disability in Antiquity

By Fareed Haj, 188 pp., $6.50, Philosophical Library, 1970.

THIS TEXT should interest those in rehabilitation and public health. It covers many of the medical and social causes of disability in the Near East during the Middle Ages.

Mutation as Cellular Process

Ciba Foundation Symposium edited by G. E. W. Wolstenholme and Maeve O'Connor, $7.32, J. & A. Churchill Ltd., 1969.

Gas Chromatography in Biology and Medicine

Ciba Foundation Symposium edited by Ruth Porter, $7.32, J. & A. Churchill Ltd., 1969.

Homeostatic Regulators

Ciba Foundation Symposium edited by G. E. W. Wolstenholme and Julie Knight, $9.15, J. & A. Churchill Ltd., 1969.

THESE EXCELLENT Ciba Symposiums are recommended for those with special interests in these fields.

MAY WE HELP YOU

TO HELP YOUR PATIENTS?

Complete Line – Orthopedic Supports

Artificial Limbs – Invalid Equipment

Certified Fitters

C. R. NEWTON CO. LTD.

1575 S. BERETANIA STREET

HONOLULU, HAWAII 96814

TELEPHONE 949-8389 OR 949-6757

Carnation
EVAPORATED MILK

HAWAII'S HEALTHY BABY MILK...



1970
Carnation Healthy Baby Contest
$1,000 1st prize winner,
David Culver Holbrook
of Honolulu, Hawaii



1st CHOICE FOR INFANT FEEDING...
No. 1 in the Islands for generations,
...available everywhere in Hawaii

"from Contented Cows"

Our "Angels"

	PAGE
Arch Laboratories	
Dicarbosil	11
Ayerst Laboratories	
Thiosulfil	8, 9
Becton, Dickinson & Co.	
BDP—Plastipak	Insert (between 44 & 45)
Bishop Trust	6
Brainard & Black	52
Burroughs Wellcome	
Empirin Compound	4
Campbell Soup Company	
Asparagus	35
Carnation Milk Co.	68
The Coca-Cola Co.	60
Hawaiian Life Insurance Co., Ltd.	60
Hawaii Medical Service Association	12
Lederle Laboratories	
Achrostatin	11
Lilly, Eli & Company	
Ilosone	14
Mead Johnson & Company	
Prosobee	13
Medical Placement Bureau	66
National Drug Company	
Orenzyme/AVC	Insert (between 4 & 5)
Tepanil/Quinamm	Insert between (12 & 13)
Newton, C. R., Co., Ltd.	67
Lydia O'Leary	69
Optical Dispensers	66
Roche Laboratories	
Efudex	64, 65
Menrium	2, 3
Valium	72
Searle, G. D., & Company	
Demulen	70, 71
Smith Kline and French Laboratories	
Dyazide	61
Star-Bulletin Printing Co.	63



BLEMISHES?

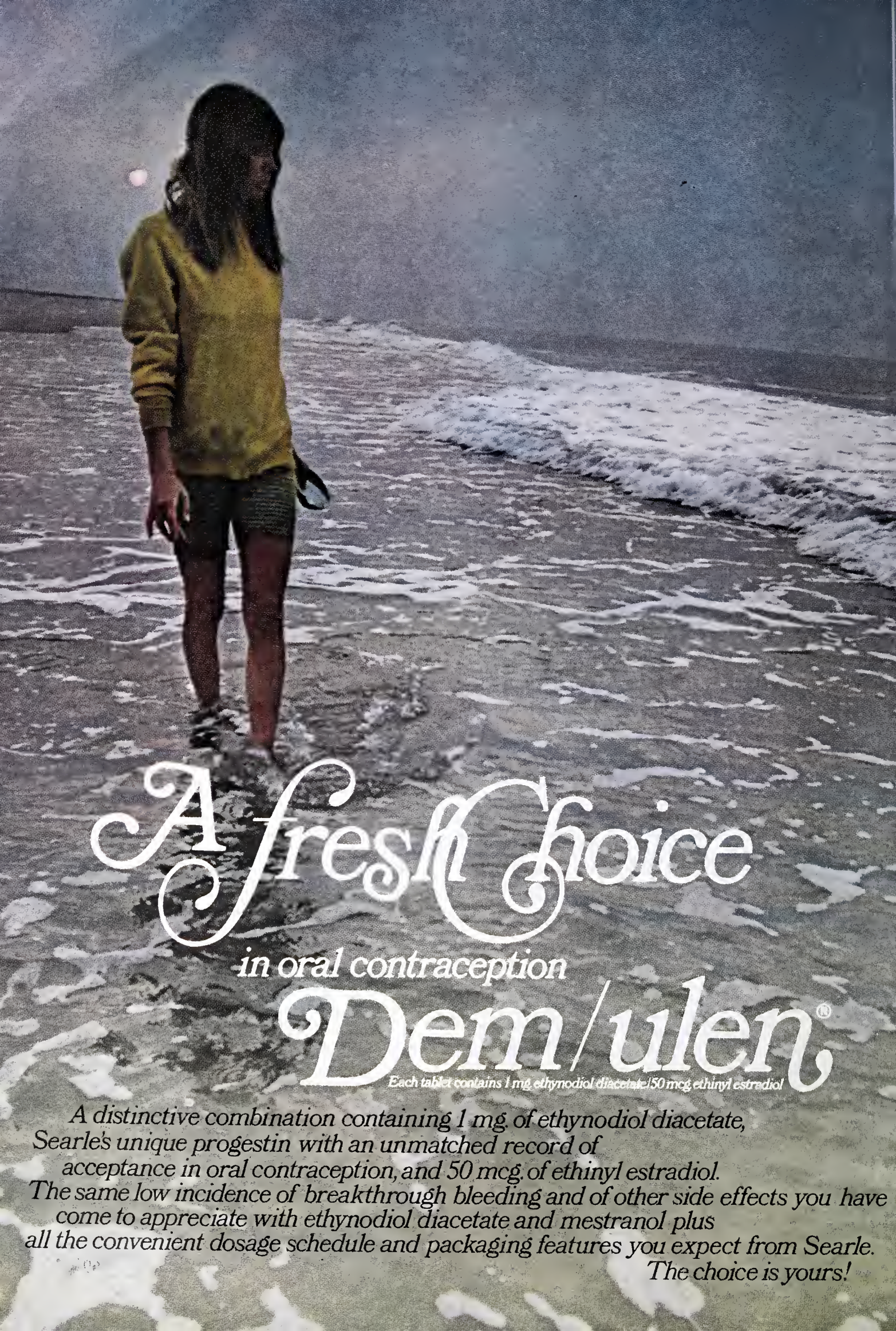
COVERMARK conceals all skin discolorations . . . birthmarks. brown & white patches, broken veins, tattoos. burns. scars. on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary

OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288

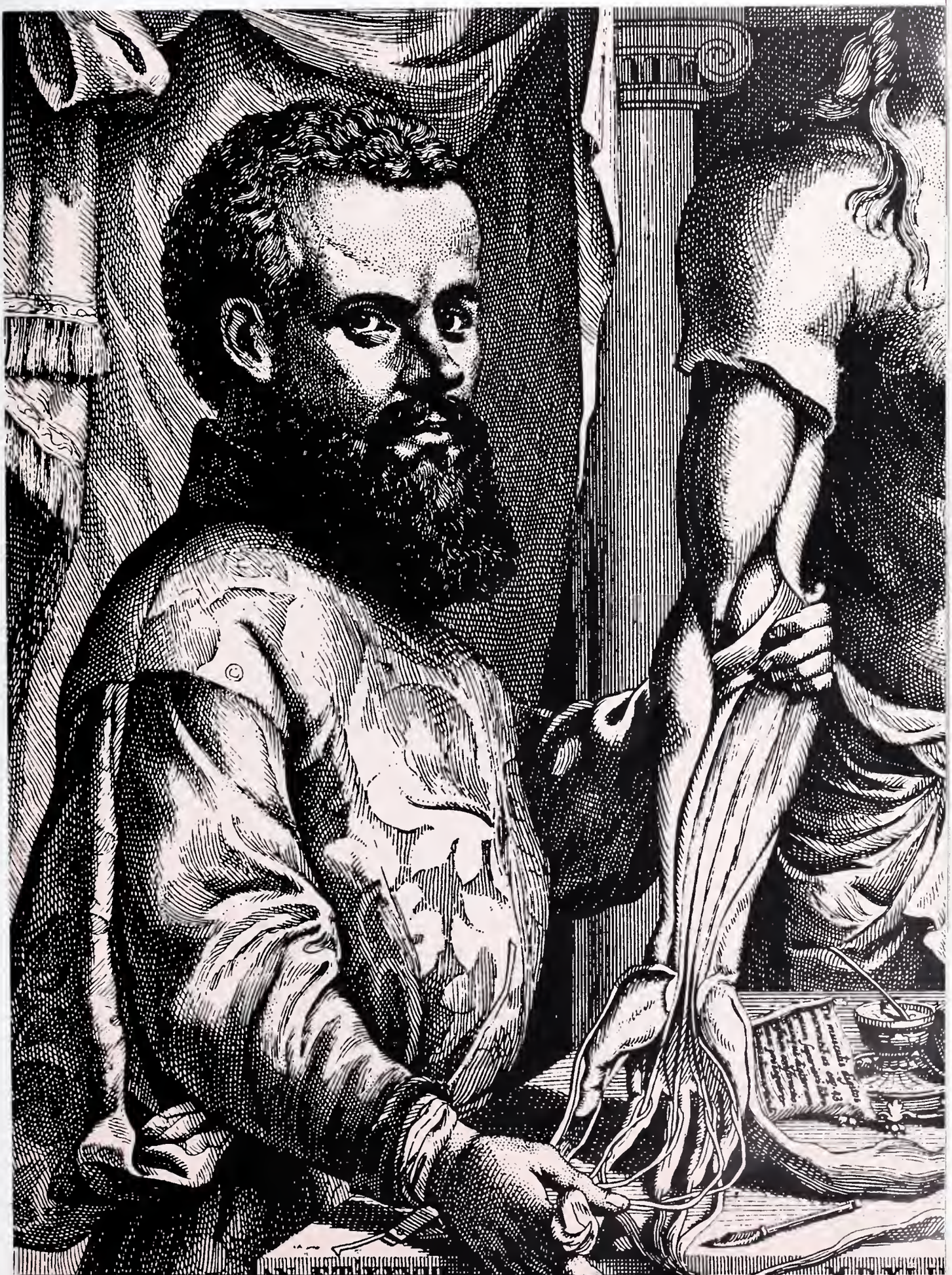

A fresh choice
in oral contraception
Demulen®
Each tablet contains 1 mg. ethynodiol diacetate/50 mcg. ethinyl estradiol
A distinctive combination containing 1 mg. of ethynodiol diacetate,
Searle's unique progestin with an unmatched record of
acceptance in oral contraception, and 50 mcg. of ethinyl estradiol.
The same low incidence of breakthrough bleeding and of other side effects you have
come to appreciate with ethynodiol diacetate and mestranol plus
all the convenient dosage schedule and packaging features you expect from Searle.
The choice is yours!

MEDICAL CENTER LIBRARY
MAY 1 1 '71

MARCH / APRIL 1971

HAWAII MEDICAL JOURNAL

VOLUME 30 / NUMBER 2



as Vesalius
1514-1564)

nder of the
lern science
of anatomy.

543 he pub-
De Humani
ris Fabrica,
st exact and
lete treatise
an anatomy
ed on actual
observation.


ROCHE

Widowed and alone
(with irritable colon syndrome)

Loss of a loved one. Loneliness. Job insecurity. The high correlation between stress factors in a patient's life and irritable colon syndrome is a matter of clinical experience.

Deal with the stress factor

Drug therapy for these patients might therefore be expected to do two things:
(1) allay anxiety associated with the irritable colon syndrome, and
(2) relax colonic spasm while checking hypermotility.
These are precisely the actions that define the effect of Librax.®

Librax: more than an antispasmodic

Librax is the only drug that delivers the tranquilizing action of Librium® (chlordiazepoxide HCl) plus the potent anticholinergic action of Quarzan® (clidinium Br). The anticholinergic helps control gastrointestinal hypermotility and spasm—the immediate cause of the patient's complaint. At the same time, the action of Librium helps ease the anxiety that may have triggered the G.I. distress in the first place.

1 or 2 capsules, 3 or 4 times daily

The dosage of Librax should be adjusted to achieve optimum individual response—within the range of 1 or 2 capsules, 3 or 4 times daily.
In most cases, a satisfactory effect is obtained with 1 capsule before each meal and 2 at bedtime. Librax: #60, sig. 1 *a.c.* and 2 *h.s.*

Before prescribing, please consult complete product information, a summary which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Roche Laboratories
Division of Hoffmann-La Roche, Inc.
Nutley, N.J. 07110

As adjunctive therapy Dual-action Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

Calms anxiety, calms the G.I. tract

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

E LEADING MANUFACTURER
F INSULIN SYRINGES

B-D

CTON, DICKINSON AND COMPANY
THERFORD, NEW JERSEY 07070

FREE CLINICAL SUPPLY

PLASTIPAK
INSULIN SYRINGE/NEEDLE UNITS

Send samples to:

Name _____
(Physician's Signature

Address _____

City _____ State _____ Zip _____

Clip out postcard on dotted line . . . no stamp required

Now you can lower the risk of insulin error when your patient is home . . . and alone



B-D

SINGLE-USE
PLASTIPAK
INSULIN SYRINGE/NEEDLE UNIT

8401
RED CAP u40

8406
GREEN CAP u80

as specific as insulin itself

Postage will be paid by Addressee

No postage stamp necessary if mailed in the United States

BUSINESS REPLY MAIL
First Class Permit No. 134, Fairview, N.J.

Becton-Dickinson and Company
Consumer Products Division
P.O. Box 183
Fairview, New Jersey 07022

Clip coupon on dotted line . . . fill out other side send for physician's free samples

THE LEADING MANUFACTURE OF INSULIN SYRINGE

B-D

BECTON, DICKINSON AND COMPAN RUTHERFORD, NEW JERSEY 070

color-coded caps and numbers—red for U40, green for U80

presterilized—consistently dependable, and sterility is assured until cap is opened

easy-to-hold, easy-to-handle—even for child diabetics with small hands or adults with stiff fingers

the sharpest needle your patient can buy—far sharper than any reusable needle

pocket-or-purse portable—sturdy from tip to top

integral cannula reduces air bubbles

single-scale PLASTIPAK insulin syringe needle units eliminate the hazard of reading the wrong scale



the first insulin syringe so low in cost your patient can use a new one every time

its single-scale—U40 or U80—minimizes the risk of measurement errors. Your patient *can't* read the wrong scale.

low cost—barely pennies higher than old-fashioned disposable needles without syringe . . . about as low as a cup of coffee

big numbers, wide spaces for easy reading

U40 **U80**

Supplied: in packages of 10—PLASTIPAK syringe U-40 (red) or PLASTIPAK syringe U-80 (green) Prescription required in most states.

BECTON B-D DICKINSON
Consumer Products Division
Becton, Dickinson and Company
Rutherford, New Jersey 07070

HAWAII MEDICAL JOURNAL

VOLUME 30, NUMBER 2

MARCH-APRIL, 1971

$6.00 A YEAR • $1.00 A COPY

Published Bi-Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, MARILYN O. WALL
Associate Editor, MERYL H. HABER, M.D.
Contributing Editor, ROBERT H. MOSER, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.

Advertising Representative
LILITH JURRY
Phone 946-0053

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1971, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter. October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

The Hawaii Medical Association

Officers 1971

President	• JOHN J. LOWREY, *Honolulu*
President-Elect	• HERBERT Y. H. CHINN, *Honolulu*
Past President	• GEORGE H. MILLS, *Honolulu*
Secretary	• R. VARIAN SLOAN, *Honolulu*
Treasurer	• THOMAS P. FRISSELL, *Honolulu*
County Presidents	
Hawaii County	• VERNE ADAMS, *Pahala*
Honolulu County	• THOMAS R. FRISSELL, *Honolulu*
Kauai County	• CHARLES CUSTER, *Waimea*
Maui County	• J. MARK B. SOWERS, *Wailuku*
Delegate to AMA	• GEORGE H. MILLS, *Honolulu*
Alt. Delegate to AMA	• THEODORE T. TOMITA, *Honolulu*

Councillors 1971

Maui	• WILLIAM E. IACONETTI
Honolulu	• GROVER H. BATTEN
Honolulu	• WILLIAM W. L. DANG
Honolulu	• RICHARD D. MOORE
Hawaii	• ED B. HELMS
Kauai	• YONEMICHI MIYASHIRO

Officers—County Societies—1971

HAWAII		HONOLULU
VERNE ADAMS •	President	• THOMAS FRISSELL
DEWITT H. SMITH •	Vice President	• WINFRED LEE
EDWARD BALLERINI •	Secretary	• WILLIAM DANG
ALLAN TAKASE •	Treasurer	• ELMER JOHNSON
MAUI		**KAUAI**
J. MARK B. SOWERS •	President	• CHARLES CUSTER
DENIS FU •	Vice President	• KATOK CHUANG
JOHN WITHERS •	{Secretary} {Treasurer}	• ROBERT BERRY

IT'S THEIR FUTURE...

But it's up to you to plan it. Your children gaze into the mystery of the future. But their lives in twenty or thirty years depend substantially on your vision today. They depend on your abilities with investments, taxes, estates, and trusts. And that's our field. We'd like to help . . .



BISHOP TRUST CO., LTD.

Bishop and King • Phone 536-3771
Honolulu, Hawaii 96813

HAWAII MEDICAL JOURNAL

Contents

Volume 30, No. 2 • March-April, 1971

Articles

Malignant Leiomyoblastoma Report of Ninth Case 89
Grayson R. Osteraas, Major, MC, and Sebbins B. Chandor, Major, MC

Plague Antibody Response in the Mongoose 92
Harry H. Higa, Ph.D., William T. Matsuura, B.S., and Walter H. Watanabe, B.S.

Scorpions and Centipedes of the Hawaiian Islands: Their Medical Significance 95
Carroll M. Martin, Major, MC

Editorials

Health Care Delivery in Hawaii 101

The Makana Foundation for Organ Transplants 101

The Mabel L. Smyth Memorial Building 102

MECO = Medical Education Community Orientation 103

Romance Never Dies 103

Features

Book Reviews 109

County Society News 113

Hawaii Academy of General Practice 106

Hawaii Medical Association 116

In Memoriam—Doctors of Hawaii—LXXXIX 112

Inside HMA 105

Letters 85

New Members 114

Notes and News 110

President's Page 100

Slants and Angles 104

X-ray View Box 108

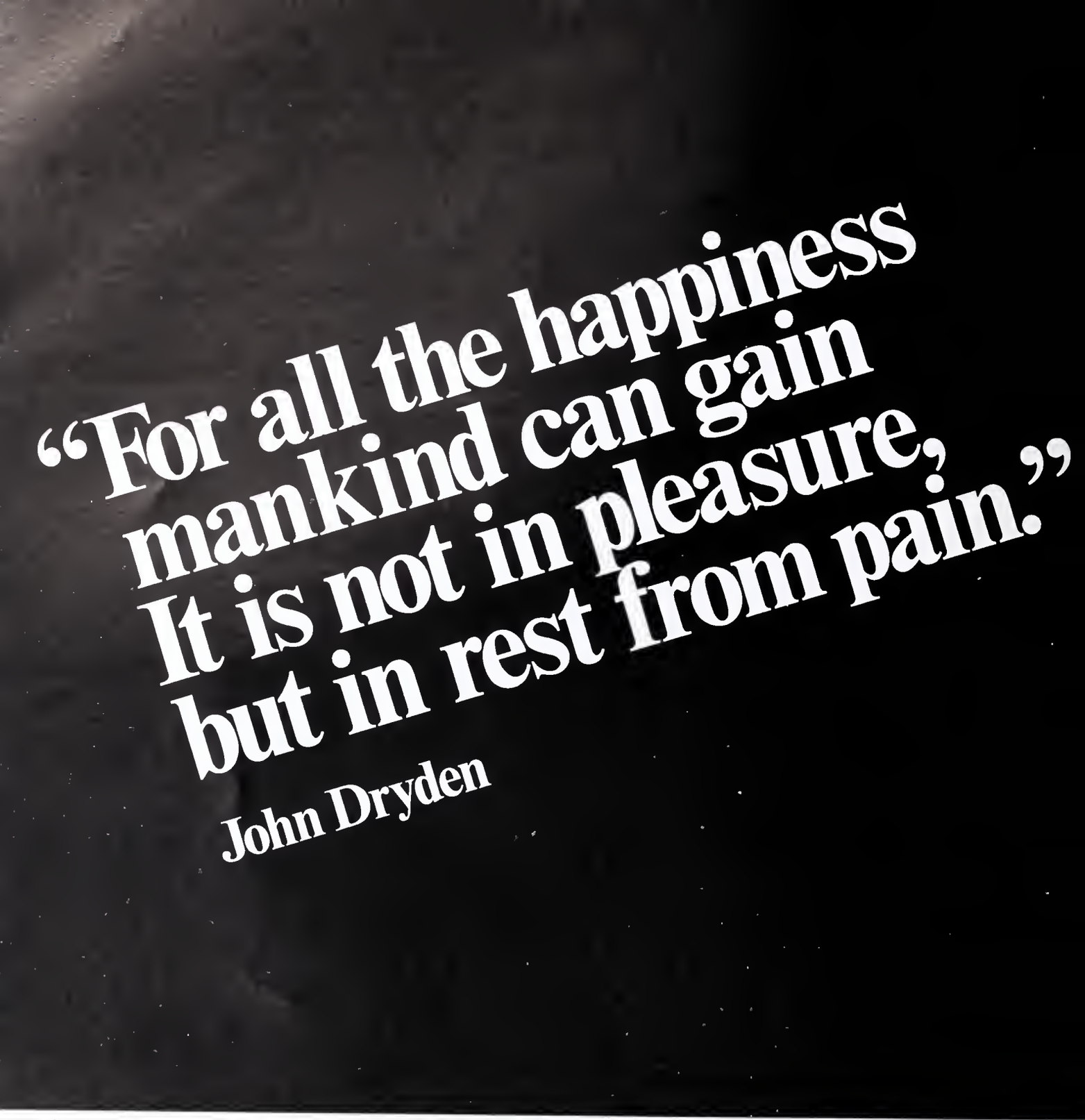
Hawaii Pharmacists' Bulletin

The President's Corner 118

Board of Directors Meeting 119

Interactions of Oral Coumarin Anticoagulants 119

Cover: From the collection of Meryl H. Haber, M.D.



Give your patients rest from pain

Empirin® Compound with Codeine Phosphate gr. 1/2, No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

B. W. & Co. narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

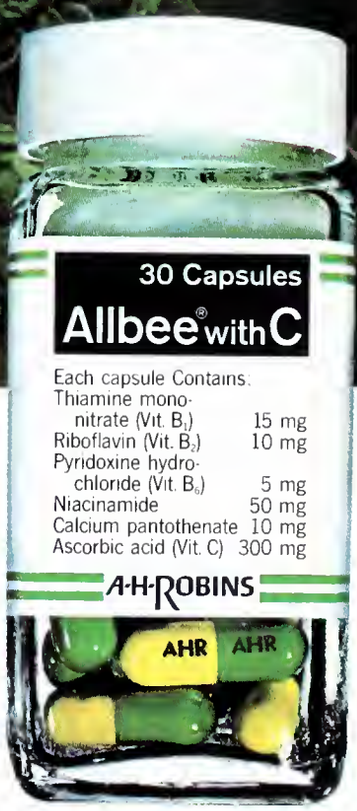
Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



2 ways to give your patients a month's therapeutic supply of Vitamin C:

40 pounds of spinach or 30 Allbee® with C



Although raw spinach is an excellent source of vitamin C, your patient would have to eat 40 pounds a month (about 1⅓ lbs. a day) to get as much ascorbic acid as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). If the spinach is cooked, a person would have to ingest more than twice as much because cooking destroys much of the vitamin C, and still more is lost when the liquid is drained off. Allbee with C also contains therapeutic amounts of B-complex vitamins. This handy bottle of 30 capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS



vacation in a vial: the spasm reactors in your practice deserve

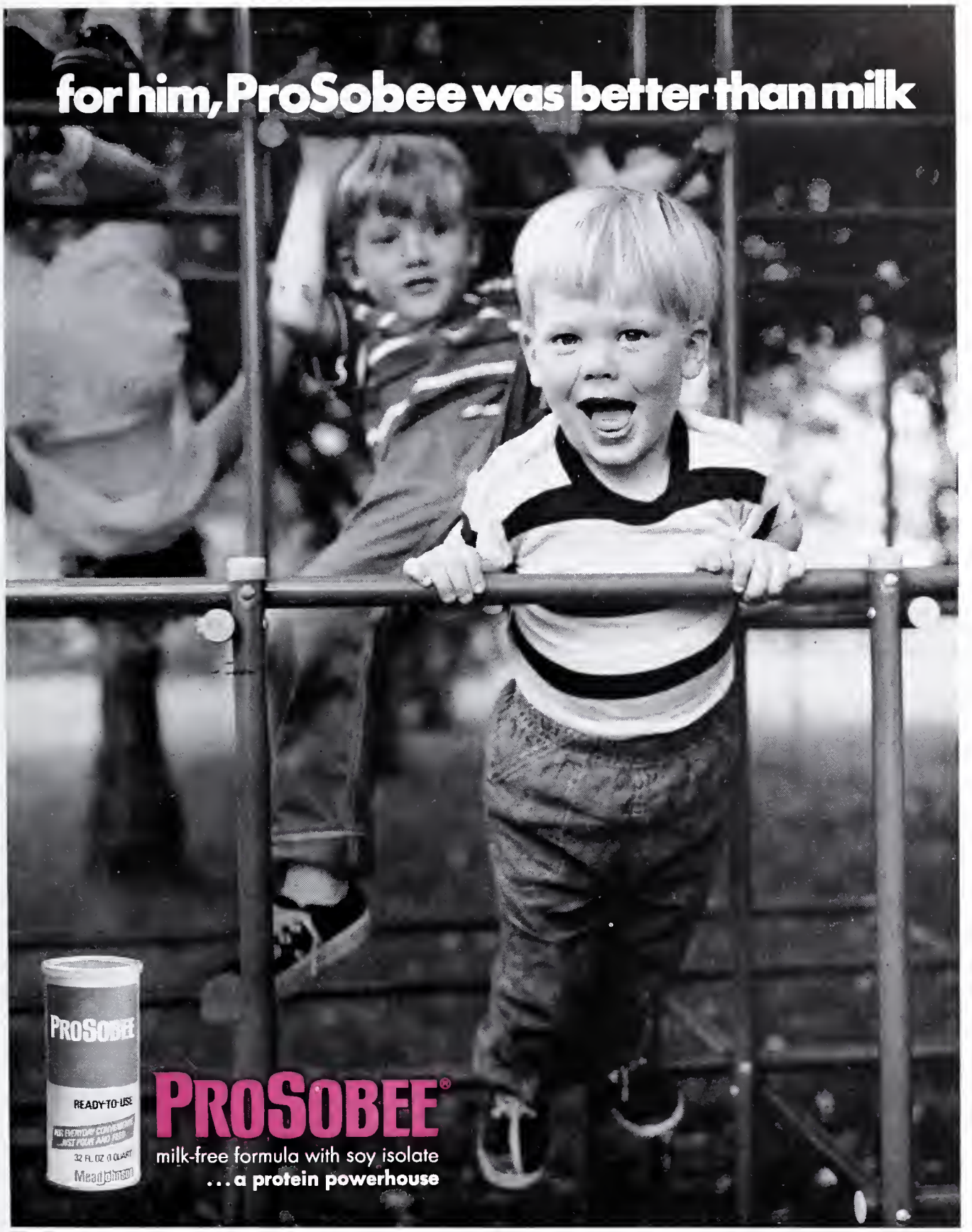
"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS



For this ex-"problem feeder" there was an extra boost of protein that helped bring protein reserves up and helped keep them there ■ he received 25% or more protein from PROSOBEE than he would have from other soy isolate formulas ■ PROSOBEE has milk-like color, smoothness and flavor for greater acceptance ■ and now, convenient 32-fl. oz. PROSOBEE Ready-To-Use—no chance for mixing error. **For Hospital Use:** NURSETTE® disposable bottles, 4- and 8-fl. oz., for the BENIFLEX® disposable nurser system, 32-fl. oz. cans.

Composition: 87% water, 3.9% sugar, 3.1% soy oil, 2.7% corn syrup solids, 2.7% soy protein isolate, 0.26% dicalcium phosphate, 0.26% potassium citrate, 0.10% lecithin, 0.05% calcium carbonate, 0.04% dibasic magnesium phosphate, 0.03% salt, 0.03% carrageenan, 0.03% guar gum, 0.02% DL-methionine, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, riboflavin, niacinamide, sodium iron pyrophosphate, potassium iodide, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, choline chloride, inositol, cupric sulfate, manganese sulfate and zinc sulfate.

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 77470

Mead Johnson
LABORATORIES

Efudex®
(fluorouracil)
cream/solution

In the treatment of solar/actinic keratoses-
An alternative to cold, fire and steel

2/23/68
Before treatment with 5% 5-FU cream. Patient R. G., 78 years old, shows extensive skin changes due to weathering and severe solar/actinic keratoses.

3/26/68
Following one month of therapy. Intense erythematous reaction is seen at sites of keratoses. Normal skin has not reacted. Some areas which had reacted initially have undergone healing despite continued topical application of 5% 5-FU.

6/11/68
Ten weeks after discontinuance of therapy. All areas have healed complete Residual mild erythema remains in som areas. This patient also had seborrheic keratoses which, as expected, have not reacted. There is no evidence of residua lesions or recurrences.



ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

An alternative to conventional therapy

Efudex (fluorouracil) offers the physician a topical alternative to cryosurgery, electrodesiccation and cold-knife surgery in the treatment of solar/actinic keratoses. It is effective, comparatively inexpensive and especially well suited for treatment of these multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When new lesions appeared, repeated courses of Efudex therapy proved effective.*

Predictable therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three months before gradually receding. Since this response is so predictable, lesions which do not respond should be biopsied.

Two strengths—two dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann - La Roche Inc., Nutley, New Jersey.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



new
Efudex®
(fluorouracil)
cream/solution



the other baby bottle*

The little green bottle of pHisoHex is the second busiest bottle in most hospital nurseries.

Baby's first bath with pHisoHex, right in the delivery room, is an initial link in a chain of anti-Staph protection for the newborn. The chain can be kept unbroken throughout the infant's stay in the hospital nursery by giving him daily baths with pHisoHex and having nurses wash their hands with pHisoHex before and after handling each infant.

With every bath, pHisoHex creates a bacteriostatic film of potent hexachlorophene on skin. There it remains *between* baths to inhibit growth of microorganisms—especially Staph.

*For external use only

Mothers can maintain this antibacterial protection at home by bathing baby exclusively with pHisoHex.

And nonalkaline, hypoallergenic pHisoHex is kind to skin. Won't tend to dry or irritate, even when used frequently.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

...the nursery formula* that stops Staph from thriving on baby's skin

pHisoHex®

antibacterial skin cleanser with 3% hexachlorophene



(1432M)

A
BUILDING BLOCK
TO RECOVERY



One tablet q.i.d.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:
☐ Accidental Trauma ☐ Postoperative Tissue Reactions.
Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.
Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.
Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.
Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 9/70 0-009A 161

Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple



Trichomonads . . . monilia . . . bacteria
You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC
Cream (aminacrine hydrachlaride 0.2%, sulfanilamide 15.0%, allantain 2.0%)

Suppositories (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.14 Gm.)

Contraindications: Knawn sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautians for topicol and systemic sulfanomides should be observed because of the possibility af absorptian. Burning, increosed local discomfart, skin rash, urticaria or other monifestatians of sulfanamide toxicity are reasans ta discantinue treatment.
Dosage: One applicatarful or ane suppository intravaginally ance ar twice doily.
Supplied: Cream – Faur-aunce tube with or without applicatar. Suppasitories – Box of 12 with applicatar.

TRADEMARK: AVC AV-104 2/71 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular

Letters

Prevalence, not Incidence!

To the Editor:

I was moved to tears of despair when I saw that you overlooked the repetitive and consistent misuse of the word *incidence* in the recent article in the HAWAII MEDICAL JOURNAL about the "Australia antigen." Please see pages 623-627 in your issue of November-December, 1970. The word *incidence* has a very precise technical meaning. It refers to the number of new cases (or events) that arise in a specified population *during a specified period of time*. It is a direct measure of the risk of experiencing the specified event (of "becoming ill"). One often converts this observation to a standard population size (100, 1000, 10,000, etc.) in order to facilitate comparison between different populations. This is then called an *incidence* rate. On the other hand, *prevalence* refers to the number of cases *existing at any one time* of observation in a specified population, and a *prevalence rate* refers to the number of cases existing in a population of standard size. When these words are used correctly, a mathematical relationship exists in any population: Prevalence = Incidence × Duration.*

In every place where the word "incidence" is used in the article you published, the terms "prevalence" or "prevalence rate" should have been substituted. For example, the first sentence in the italicized summary of the article should have read, "The *prevalence rate* of Australia antigen in the normal population of Hawaii is 0.12%." Even this "corrected" statement is not warranted by the data presented in the body of the article, where the authors were very careful to put the word "normal" within quotation marks. Any prevalence or incidence statement should refer, if possible, to a specific population, defined as to age, sex, race, and location. In this article one of the "normal" groups was made up of Honolulu Heart Program participants (Japanese men, born between 1900 and 1919, now resident on Oahu), some of whom have a variety of disease. We are not informed as to what criteria were used for selecting the 3865 sera tsted out of the 8000 available from the HHP group. The other "normal" group was 6388 sera from donors to the Blood Bank of Hawaii, who are screened for some diseases and usually are between 20-60 years of age, but may include people who do not live in Hawaii.

If we are to consider prevalence data to test the hypothesis that the Australia antigen is a virus capable of causing hepatitis, then we should make every effort to separate distinct groups with varying known risks. For example, we should look at those who have had blood transfusions recently in comparison with those who have never had any, but who are otherwise matched as to age, sex, race, location, and socio-economic status. We should look at children living in unsanitary environments in comparison to those with flush toilets and good water. We should look at young heroin addicts in comparison with young people not on heroin.

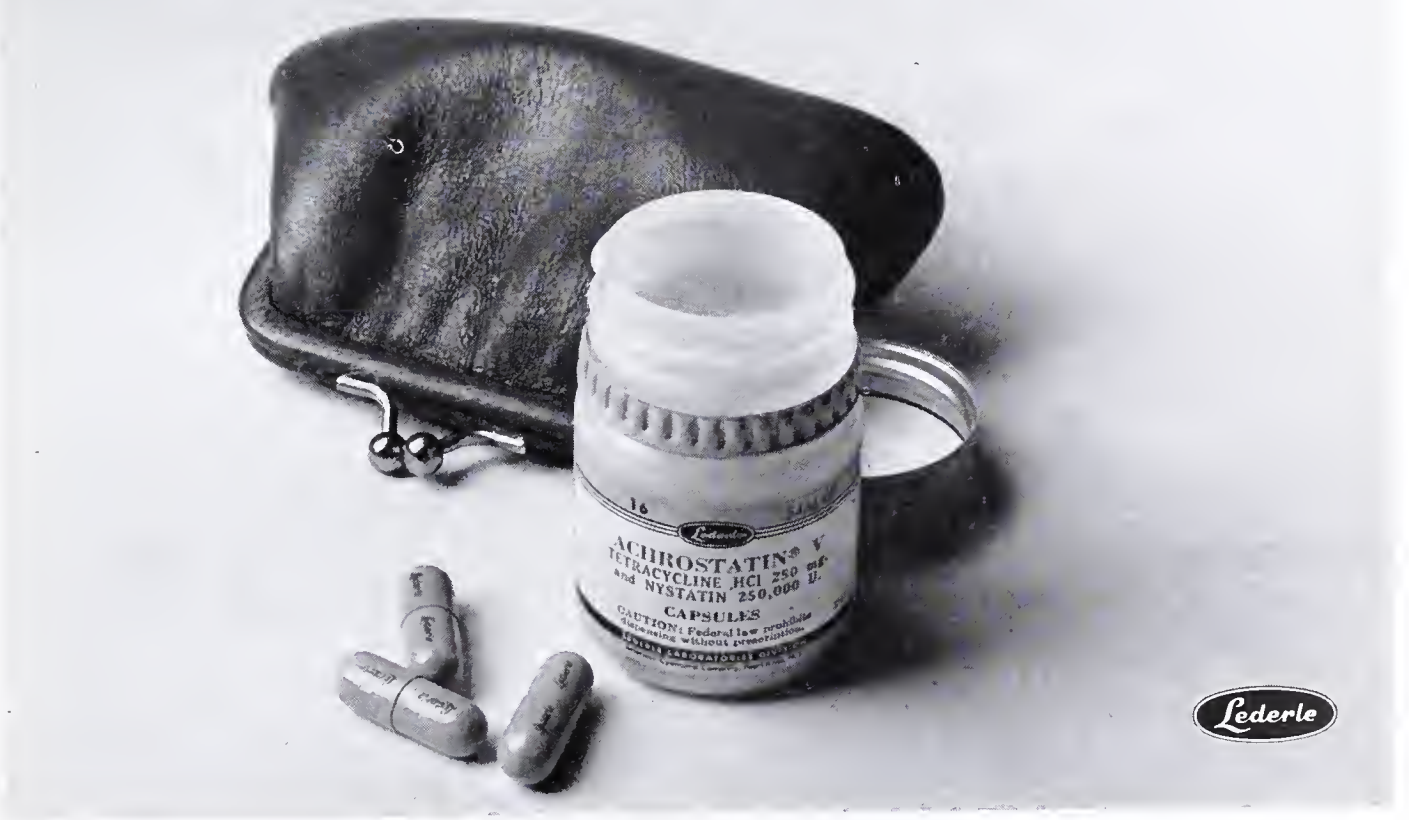
Incidentally, among the greatest transgressors in this incidence-prevalence game are the leprologists, most of whom persist in doing leprosy prevalence surveys and reporting them as "incidence." The leprosy literature abounds with a high prevalence of this error, and the incidence of new episodes supports the hypothesis that no effective preventive measure has yet been found.

Epidemiologically yours,

ROBERT M. WORTH, M.D., Ph.D.
Professor of Public Health
University of Hawaii

* Duration = the average length of time between the onset of the disease or condition and its termination through cure or death.

—The lowest priced tetracycline—nystatin combination available—



"I'M FEELING
MUCH BETTER, DOCTOR."

"SO AM I."



HMSA is the "get-well card" that leaves you *both* feeling better. Offers patient and physician lasting relief from medical economic problems. Once again, March, July and November are individual enrollment months. An excellent time to remind unprotected patients about the benefits of belonging to this non-profit community organization. It's good for what ails them. And you.

HMSA

Hawaii-owned for Hawaii's own
HAWAII MEDICAL SERVICE ASSOCIATION
BLUE SHIELD PLAN FOR HAWAII
Member Western Conference of Prepaid Medical Service Plans

HONOLULU: 1504 Kapiolani Blvd., P. O. Box 860, Phone 944 2110
WAILUKU, MAUI: P. O. Box 956, Phone 323 912
LIHUE, KAUAI: P. O. Box 27, Phone 245 3393
HILO, HAWAII: P. O. Box 1356, Phone 935 5441
KAILUA-KONA, HAWAII: P. O. Box 1219, Phone 329 3030


Thorazine®
brand of chlorpromazine
versatility
quality
experience
NOW THERE'S A PRICE
Smith Kline & French Laboratories SK&F



Not too little, not too much... but just right!

"Just right" amounts of Ilosone Liquid 250
can be dispensed easily from the pint bottle in *any* quantity
you specify to meet your patients' precise needs—
without regard to package size.

ready-mixed
Ilosone® Liquid 250

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

100204

Case Report

Malignant Leiomyoblastoma Report of Ninth Case

This rare neoplasm may on occasion be highly malignant, as this case shows.

GRAYSON R. OSTERAAS, MAJOR, MC, and
STEBBINS B. CHANDOR, MAJOR, MC, *Honolulu*

This report presents the ninth case of malignant leiomyoblastoma. Because the gross appearance of malignant leiomyoblastoma cannot be differentiated from that of the more common benign variety of leiomyoblastoma, we feel that a careful abdominal exploration is mandatory when a smooth muscle tumor of the stomach is discovered. An increased mitotic figure index in a leiomyoblastoma is a useful criterion of malignancy.

EPITHELIOID or bizarre leiomyoblastoma was defined in the medical literature by Stout in 1962.[4] The majority of cases included in his series arose in the gastrointestinal tract and followed a benign course; however, Stout's series and subsequent reports have documented the malignant potential of this lesion. Thus far, satisfactory histologic criteria indicative of malignancy have not been firmly established except possibly the mitotic index.

This is the ninth report of a gastric leiomyoblastoma which metastasized widely and had an increased mitotic index.

CASE HISTORY

In September of 1967, the patient, a 54-year-old Caucasian man, presented with an upper abdominal mass which he had noticed over the previous year. Subsequent laparotomy revealed an unresectable tumor of the distal stomach, retroperitoneum, and liver. Diagnosis at this time was liposarcoma. The mass was given 3000 R of x-radiation.

In August of 1968, he developed ascites, and edema of the scrotum and lower extremities. Studies with intravenous contrast media showed total occlusion of the inferior vena cava in the upper abdomen. The ascites and edema were controlled with oral diuretics for the next four months.

On 11 December 1968, recurrent ascites, edema, and a right pleural effusion appeared, and the patient persistently lost weight. BUN was 28 mg%, SGOT 61 IU, LDH 143 IU, and alkaline phosphatase 18 Bodansky units. Total bilirubin was 0.8 mg%, half of it direct. Increasing respiratory distress appeared, he rapidly deteriorated, and he expired on 24 February 1969. His total clinical course was about two and a half years.

At autopsy, the body was that of a cachectic middle-aged Caucasian man, with marked edema of the lower extremities and scrotum. All serous cavities contained clear yellow fluid; the peritoneal cavity contained 3,000 cc, the right pleural cavity 1,000 cc, and the left pleural cavity 300 cc. The tumor involved the muscularis of pylorus and the lesser peritoneal sac, and it surrounded the inferior vena cava and studded the serosal surfaces of small bowel, colon, and urinary bladder. The liver weighed 5,250 grams and contained numerous tumor nodules, predominantly in the left lobe. The tumor nodules were smooth, firm, white, and well circumscribed, with small foci of hemorrhage.

Microscopic examination disclosed a tumor nodule apparently arising in the muscularis of the pylorus (Fig. 1). Within the nodule the predominant type of cell had vesicular nuclei and finely granular perinuclear eosinophilic material (Fig. 2). The latter substance occasionally formed strands radiating out from the nucleus. The outer portion of the cytoplasm was often clear, and the cell margins indistinct. Special stains, including PAS, oil red O, and mucicarmine, were negative.

A few areas contained aggregates of spindle cells with oval nuclei having the appearance of typical smooth muscle cells (Fig. 3). Tumor nodules in the liver were cuffed by bands of connective tissue with varying degrees of hepatocellular degeneration adjacent to the tumor. The

APO San Francisco 96438.
Received for publication July 15, 1970.



FIG. 1.—*Tumor nodule, pyloric muscularis. Hematoxylin and cosin, × 5.2.*

predominant type of cell found in the liver and other metastatic sites was the epithelioid cell. PAS and reticulum stains (Fig. 4) demonstrated, in some areas, a membrane-like structure around small nests of cells. Masson trichrome revealed minimal connective tissue strands within the tumor stroma. Several observers noted mitotic indices varying from 16 to 27 per high-power field.

DISCUSSION

Martin *et al*[2] initially brought attention to atypical gastric myoid tumors. Stout[1] in discussing his series vividly documented the difficulties encountered in arriving at the correct diagnosis with these lesions. One hundred and eight diagnoses were entertained for the 69 lesions reported, and a large percentage of the diagnoses was of a malignant tumor. This was also demonstrated here in the initial diagnosis, and in the discussion that arose in reviewing the autopsy slides. In fact, only

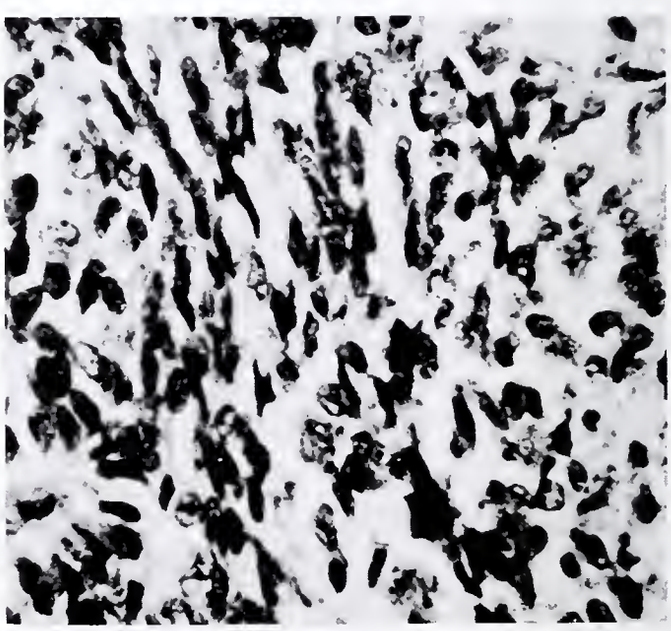


FIG. 2.—*Tumor in pyloric muscularis. Masson trichrome, × 800.*

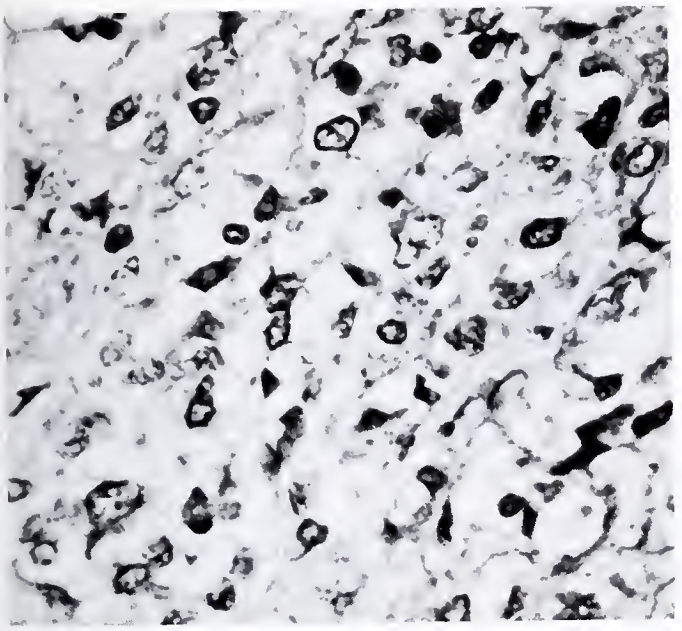


FIG. 3.—*Tumor nodule, anterior peritoneum. Hematoxylin and eosin, × 800.*



FIG. 4.—*Tumor in pyloric muscularis. Reticulum, × 800.*

two of the lesions were malignant as evidenced by metastasis. Three additional malignant leiomyoblastomas appeared in a report by Yannopoulos and Stout.[5] Rachman,[3] Wellman,[6] and Cornog[1] have contributed single case reports.

In Rachman's discussion of the histologic and cytologic characteristics of malignant leiomyoblastoma, he suggests the possibility of pericytic origin of the tumor. Electron microscopic studies by Cornog show cytoplasmic organelles which are not observed in smooth muscle, but the cells do contain intracellular bundles of filaments with regular transverse periodicity. Subsequent investigations[7, 8] have confirmed the presence of similar filamentous structures, simulating myofilaments, in additional cases of leiomyoblastoma. Thus the evidence at present suggests the tumor is of smooth muscle origin.

The "clear cell" which has perinuclear vacuolization has been the hallmark of leiomyoblastoma when studied by light microscopy. Electron-microscopic studies have failed to confirm the presence of large intracytoplasmic vacuoles,[1, 7, 8] however, and in one case report[8] the vacuoles were not seen in fresh frozen material or in glutaraldehyde-fixed material studied by light microscopy. The latter findings support Cornog's postulate that the vacuoles are artifacts induced by formalin fixation.

What is the correlation between malignancy of a leiomyoblastoma (i.e., its capacity for metastasis) and the mitotic figure index (i.e. number per 50 high-power fields) of the tumor? Stout's original cases were characterized by a low mitotic figure index, i.e. 2 or less mitotic figures per 50 high-power fields. The cases in which metastasis occurred did show isolated areas with 13 to 19 mitotic figures per high-power field. With this finding in mind, he felt malignancy should be suspected if the tumor contained areas with an elevated mitotic index, i.e. greater than 2 per 50 high-power fields. Subsequent reports have confirmed this hypothesis: Rachman 3/50 HPF, Wellman 12/50 HPF, and Cornog 10/50 HPF.

There has been one case report of nonmetastasizing leiomyoblastoma with a markedly elevated mitotic index of 41/50 HPF.[9] The author concluded the elevated mitotic rate indicated a potential for metastasis, but the tumors with an increased mitotic index do not necessarily metastasize, or may metastasize only after a long time. Our case presented above showed an average of 20 mitoses per high-power field. We feel that a leiomyoblastoma which has areas of increased mitotic activity, that is, greater than 2 to 5 mitoses per 50 high-power fields, should be considered malignant.

ACKNOWLEDGMENT

We wish to thank Dr. F. M. Enzinger, Chief of the Soft Tissue Branch, Armed Forces Institute of Pathology, for reviewing the material in this case.

REFERENCES

1. Cornog JL: The ultrastructure of leiomyoblastoma. *Arch Path* 87:404, 1969.
2. Martin JF, Bazin P, Feroldi J, et al: Tumeurs myoides intramurales de l'estomac; considerations microscopiques à propos de 6 cas. *Ann Anat Path* 5:484, 1960.
3. Rachman R, Mcranze DR, Zibelman CS, et al: Malignant leiomyoblastoma. *Am J Clin Path* 49:556, 1968.
4. Stout AP: Bizarre smooth muscle tumors of the stomach. *Cancer* 15:400, 1962.
5. Yannopoulos K, Stout AP: Primary solid tumors of the mesentery. *Cancer* 16:914, 1963.
6. Wellmann KF: "Bizarre leiomyoblastoma" of the retroperitoneum: report of a case. *J Path Bact* 94:447, 1967.
7. Kay S, Still WJS: A comparative electron microscopic study of a leiomyosarcoma and bizarre leiomyoma (leiomyoblastoma) of the stomach. *Amer J Clin Path* 52:403, 1969.
8. Salazar H, Totten RS: Leiomyoblastoma of the stomach, an ultrastructural study. *Cancer* 25:176, 1970.
9. Smethwick W III, Biescher JL, Leand PM: Leiomyoblastoma: behavior and prognosis. *Cancer* 24:996, 1969.

Plague Antibody Response in the Mongoose

Mongooses eat plague-infected rats and develop immunity against plague as a result: a useful indicator of infection.

HARRY H. HIGA, Ph.D., WILLIAM T. MATSUURA, B.S., and WALTER H. WATANABE, B.S., *Honolulu*

Fraction I antibody is demonstrable in the peripheral blood of the mongoose, Herpestes auropunctatus, *following subcutaneous inoculation of avirulent Pasteurella pestis EV (51f) organisms. Oral inoculation of mongooses with these organisms stimulates the production of plague antibodies. With an oral dosage of 27 x 10^9 viable organisms, four out of five mongooses showed antibody responses. The mongoose can be an indicator of natural plague infection in the field and the hemagglutinating antibodies are dependable indicators for latent plague.*

THIS WORK was performed in the plague research laboratory loeated in Honokaa, District of Hamakua, Island of Hawaii, an area designated as endemie for plague. By using Pasteurella pestis EV (51f), an avirulent strain, we intended to learn whether or not hemagglutinating antibodies are dependable indicators for latent plague, sinee no isolations of P pestis have been made within the past 12 years in the Hamakua District. Since the mongoose may eat rats, known hosts for plague organisms, it was of interest to determine whether or not oral inoeulation of viable avirulent plague organisms would elicit antibodies, thereby indieating natural plague infection in the field.

This investigation was supported in part by Grant No. A1-02886-09 by the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Public Health Service, U. S. Dept. of Health, Education and Welfare, Charles M. Wheeler, Ph.D., Principal Investigator, and the Department of Health, State of Hawaii.
Received for publication January 21, 1970.

Consequently, mongooses were inoeulated with avirulent plague organisms by both the oral and subcutaneous routes. The subcutaneous route was used to verify that the Fraetion I plague antibodies produced were speeifically those of the avirulent strain used. The sera of these mongooses were then subjeeted to the passive mierohemaggluti-nation test.

MATERIALS AND METHODS

Bacteriology

A culture of avirulent Pasteurella pestis EV (51f) was obtained from Dr. K. F. Meyer of the Hooper Foundation, University of California Medical Center, San Francisco, California.

Preparation of Inoculum. P. pestis EV (51f) organisms were grown on blood agar surfaces in 16-ounee preseription bottles. The blood agar was made with heart infusion agar (Difeo) to which sheep's red blood cells (defibrinated blood) were added at a 5% concentration.

The blood agar surface was then inoeulated with 1.5 ml of a 48-hour P. pestis EV (51f) broth eulture which had been incubated at 37°C. The broth eonsisted of brain-heart infusion (Difco) eontaining 5% sheep's defibrinated blood. The inoeulated blood agar was then incubated at 37°C for 48 hours.

Subsequently, the cultured organisms on the blood agar surface were washed off with 5.0 ml of sterile saline and the number of viable organ-

isms per milliliter determined by the plate count method. After the count was determined, appropriate dilutions were made with 10% nutrient broth in saline to obtain the desired dosages of viable organisms for the inoculations.

Immunological schedule. The experiment was divided into two groups. Group I involved mongooses which had been previously immunized by P. pestis vaccine.[1] The immune titers in these animals, having dropped, were now rather low. These mongooses were inoculated subcutaneously in the right inguinal region. Group II involved normal, recently captured mongooses. These animals were inoculated orally through a slightly bent cannula two inches long. Group I mongooses received the following dosages of viable organisms subcutaneously: 2.7 x 10^9, 270 x 10^6, and 27 x 10^6. The oral dosages of Group II were as follows: 27 x 10^9, 2.7 x 10^9, and 0.27 x 10^9. These dosages of various numbers of organisms were concentrated in 1.0 ml. Whenever feasible, five mongooses were inoculated with each dosage.

The animals of Group I were bled from the heart at intervals of 7, 14, and 21 days, while those in Group II were bled at intervals of 10, 28, 42, and 55 days. The passive microhemagglutination test was performed on the sera obtained.

All mongooses of Group II were determined to be serologically negative for antibodies of P. pestis prior to inoculation with the EV strain.

Serology

Fraction 1. This purified P. pestis antigen was obtained from Dr. K. F. Meyer of the Hooper Foundation at the University of California Medical Center at San Francisco, California. The method of preparation is essentially that of Baker et al.[2, 3]

Microhemagglutination test. The passive hemagglutination techniques used were essentially those recommended by Meyer et al.[4] These techniques were adapted to the microtechnique of Sever[5] A comprehensive treatment of the passive microhemagglutination (mHA) test is given by T. H. Chen and K. F. Meyer.[6] It essentially consists of mixing sheep red blood cells, sensitized with tannic acid and plague (Fraction I) antigen, with two-fold test serum dilutions. The red cells coated with antigen and the serum dilutions are mixed in equal amounts (0.025 ml) with a pipette dropper and calibrated loops, using a plastic plate (Plexiglas) with cups to contain the tests. The incubation time and temperature may vary according to the performer. Two hours at room temperature is recommended. With the tests in this experiment, incubation time and temperature were overnight at 4°C. Results were read in the morning.

RESULTS

The results are summarized in Tables 1 and 2. In Table 1, previously vaccine-immunized adult

TABLE 1.—*Immunogenicity of mongooses* (H. auropunctatus) *to Pasteurella pestis EV (51f) inoculated subcutaneously.*

Group I. Previously vaccine* immunized. Mongooses were inoculated subcutaneously in the right inguinal region wtih viable P. pestis EV (51f).

DOSAGE	ANIMAL NO.	PREINOCULATION	mHA (TITERS IN RECIPROCALS) *Days* 7	14	21
Large dose	200	128	512	256	128
2.7 x 10^9	201	32	512	512	1024
organisms	202	16	512	2048	1024
in one ml	203	32	4096	4096	1024
	204	16	2048	2048	1024
Medium dose	205	8	512	512	256
270 x 10^6	206	8	2048	2048	2048
organisms	207	16	128	1024	1024
in one ml	208	8	2048	1024	256
	209	32	512	2048	2048
Light dose	210	64	512	8192	4096
27 x 10^6	211	4	64	1024	512
organisms	212	8	512	2048	2048
in one ml	213	0	512	D.b.†	
	214	32	128	1024	256
Controls	C1	64	32	D.b.†	
POSITIVE		640	640	1280	1280
NEGATIVE (Normal rabbit serum)		0	0	0	0

* 2.3 × 10^9 organisms/ml
† Died bleeding.

TABLE 2.—*Immunogenicity of mongooses* (H. auropunctatus) *to Pasteurella pestis EV (51f) inoculated orally.*

Group II. Normal recently captured adult mongooses inoculated orally with viable P. pestis EV (51f).

DOSAGE	ANIMAL NO.	PREINOCULATION	mHA (TITERS IN RECIPROCALS) *Days* 10	28	42	55
Large dose	100	0	0	0	0	0
27 x 10^9	101	0	8	8	4	4
organisms	102	0	8	4	±	8
in one ml	103	0	32	Died (N.S.)		
	104	0	128	128	32	64
Medium dose	105	0	64	32	16	32
2.7 x 10^9	106	0	0	0	0	0
organisms	107	0	0	0	0	0
in one ml	108	0	0	0	0	0
	110	0	16	16	4	8
Light dose	112	0	0	0	0	0
0.27 x 10^9	114	0	0	0	0	0
organisms in one ml	115	0	4	N.S.	16	32
Control	109	0	0	0	0	0

N.S.: No serum.

mongooses (Group I) with the exception of mongoose No. 213, showed initial titers varying from 1:8 to 1:128. Vaccine-immunized mongooses were employed in previous studies[1] for the detection of specific Fraction I antibodies in the peripheral blood. These vaccine-immunized mongooses were inoculated subcutaneously and the sera tested for hemagglutinating antibodies at weekly intervals for three weeks. The data indicate that regardless of the dosages—large, medium or light —the antibody responses of the mongooses showed individual variations.

Group II, normal recently captured mongooses as presented in Table 2, were inoculated orally with viable P. pestis EV (51f) organisms. The response demonstrates that plague organisms introduced into the gastrointestinal tract may stimulate the production of plague antibodies. This is most clearly shown in the table where 27 x 10^9 viable organisms were given as the inoculum. Four out of five mongooses responded. No tests for the presence of cells of P. pestis were made in the tissue of the intestinal tracts of sero negative animals. The sera were tested for the presence of hemagglutinating antibodies at intervals of 10, 28, 42 and 55 days.

In all work dealing with mongooses, extreme care is necessary in handling because of the vicious nature of these animals.

DISCUSSION

From the results in Table 1, the responses in mHA titers may be the results of the production of "booster" responses, that is, rapid rise and corresponding fall in titers. The data in Table 1 are insufficient to indicate the corresponding fall in titers, although this phenomenon was demonstrated in earlier unpublished experiments of Meyer, McNeill and Wheeler.[1] This work demonstrates that previously immunized mongooses may develop Fraction I antibodies in the peripheral blood following the subcutaneous inoculation of avirulent P. pestis EV (51f) organisms.

Table 2 shows that among the Group II mongooses inoculated orally with viable P. pestis EV (51f), individual variations existed with respect to antibody response, as shown in Table 2; it seems probable that plague organisms do not readily reach the antibody-producing cells via the gastrointestinal tract in all individuals.

Intestinal plague has been observed in man, and in some experiments on Macaca mullata (monkeys) using virulent strains, ulcers have resulted in the stomach and small intestines, according to K. F. Meyer.

It is established that the mongoose will feed on rats. It therefore appears possible that the mongoose could feed on plague-infected rats and harbor the organisms for an indefinite period.

Studies of the contents of the stomach and intestines, as well as stools of the mongoose in Hawaii, by Kami[7] show that this animal is an omnivorous feeder. In the Waipio Valley, which is the northwestern boundary of the known plague endemic area of Hamakua, the intestinal and fecal contents of mongooses consisted chiefly of rodent remains. Of 31 mongoose sera tested from this area, 9 (29%) were reactors and 4 (12.9%) were positive, with titers up to 1:64.

SUMMARY

Hemagglutinating antibody levels were determined in the sera of mongooses which had been inoculated subcutaneously and orally with avirulent plague organisms (P. pestis EV (51f) by the microhemagglutination test.

For subcutaneous injections, vaccine-immunized mongooses with low hemagglutinating antibody titers were employed. Results show definite increase in mHA titers. Oral inoculations brought about definite low-titer antibody response.

The results obtained from these experiments demonstrate (a) that the positives of Group II mongooses could be representative indicators of natural plague infection in the field and (b) that the hemagglutinating antibodies (Fraction I) are indicators of inapparent P. pestis infection in mongooses.

ACKNOWLEDGMENT

The authors wish to thank Dr. K. F. Meyer, University of California Medical Center, for furnishing the avirulent strain of P. pestis EV (51f) and for his advice and consultation. We are indebted to Dr. L. R. Berger of the University of Hawaii, Department of Microbiology, Honolulu, for reading and correcting the manuscript. We also wish to thank Mr. Frank Soares for technical assistance and all around help in caring and handling of animals.

REFERENCES

1. Meyer KF, McNeill D, Wheeler CM: Results of a preliminary serological survey of small mammal populations for plague on the island of Hawaii. Bull Wld Hlth Org 33:809-815, 1965.
2. Baker EE, Sommer H, Foster LE, et al: Antigenic structure of Pasteurella pestis and the isolation of a crystalline antigen. Proc Soc Exptl Biol Med 64:139-141, 1947.
3. Baker EE, Sommer H, Foster LE, et al: Studies on immunization against plague I. The isolation and characterization of the soluble antigen of pasteurella pestis. J Immunol 68:131-145, 1952.
4. Meyer KF, Humphreys FA, Knopp W, et al: *Diagnostic procedures and reagents,* 4th ed, p. 389-390, American Public Health Association, New York, 1963.
5. Sever JL: Application of a microtechnique to viral serological investigations. J Immunol 88:320-329, 1962.
6. Chen TH, Meyer KF: An evaluation of pasteurella pestis fraction 1—specific antibody for the confirmation of plague infections. Bull Wld Hlth Org 34:911-918, 1966.
7. Kami HT: Foods of the mongoose in the Hamakua district, Hawaii. Zoonoses Research 3:165-170, 1964.

Scorpions and Centipedes of the Hawaiian Islands: Their Medical Significance

Hawaii is fortunate in having only one species each of centipedes and scorpions. They aren't lethal.

CARROLL M. MARTIN, MAJOR, MC, USA, *Honolulu*

In Hawaii, there is only one harmful species of scorpion—Isometrus maculatus—which produces predominantly a local reaction. There are no species which secrete the more lethal neurotoxin. There is only one harmful centipede—Scolopendra subspinipes—which also causes mainly a local reaction. Although symptoms may be severe and disabling when they are at their peak, the course is self-limited and of short duration. Treatment is symptomatic — injection of a local anesthetic into the site of the sting.

ALTHOUGH RELATIVELY few venomous animals are found in the Hawaiian Islands, there are a species of scorpion and a species of centipede which are capable of inflicting enough harm to cause the victim to seek medical attention. In the last six months, Tripler General Hospital has received several inquiries regarding the management of patients inflicted with the sting of these arthropods. At least four cases have been treated in our various outpatient facilities. No patients have required hospitalization. This report presents a brief review of the biology of scorpions and centipedes, and the management of the injuries they can inflict.

Received for publication January 1, 1970.

SCORPIONS (ARACHNIDA)

Scorpions are venomous arachnids possessing four pairs of legs and two body segments—the anterior unsegmented cephalothorax and the posterior segmented abdomen (Fig. 1). The abdomen has a broad anterior seven-segmented part and a six-segmented posterior part. On the anterior end of the cephalothorax are large bilateral pencil-like pedipalps terminating in sharp,



FIG. 1. — *Scorpion—Isometrus maculatus. Note the young scorpions attached to the dorsal aspect of the abdomen.*

strong claws. On the posterior end of the abdomen is located a bulbous segment, the telson, which terminates in a hollow stinger. The telson contains two venom glands.[1-3]

Adult scorpions vary from one to eight inches in length. Most species are nocturnal and prefer dark, hidden recluses during the day. Frequently they will enter houses and are often discovered by unsuspecting tenants in their clothes or shoes. Although in many areas of the world scorpions prefer dry, hot environments, in Hawaii they can be found in the dry coastal areas or the wet mountainous valleys with equal frequency.

There are a large number of species of scorpions with worldwide distribution. In the Hawaiian Islands there is only one species, Isometrus maculatus.[4] Unlike the more dangerous neurotoxic genera such as the Buthus in the Mediterranean area, Scorpio of Northern Africa, or Centruroides of the southwestern United States, Isometrus does not possess a potent neurotoxin and generally causes only a mild to severe local reaction.

The venom of the scorpion is a clear, colorless secretion containing varying amounts of neurotoxins, hemolysins, hemorrhagins, leukolysins, agglutinins, coagulants, ferments, lecithin, cholesterin, and cardiotoxins.[2-5] The different proportions of these various compounds are species-dependent. The hemorrhagin is responsible for the hemorrhagic and necrotic changes at the site of injection; the neurotoxin causes the predominant symptoms which are detected clinically.

Generally, the medical importance of the species of scorpion is determined by its habitat and the potency of its venom, not by its size. However, in Faust and Russell's text, it is stated that the large species are most likely to produce serious reactions. It is implied that this is a function of the volume of venom delivered and the ability of the larger species to penetrate clothing and skin with their stingers. As with most venomous animals, young children and debilitated persons suffer the most severe symptoms when stung.

The reactions produced by the non-neurotoxic species, such as Isometrus maculatus, are characterized by severe pain and swelling at the site of stinging. The swelling may spread over a wide area. Systemic symptoms are usually absent, although occasionally myalgia and nausea are reported. These symptoms usually remit within 24 hours. Occasionally proteinuria, glucosuria, or acetonuria has been reported.

Although there are no dangerous neurotoxic species in Hawaii, the clinical syndrome resulting from their sting will be briefly described to allow comparison to the reactions of the less dangerous local species. There is generally an immediate intense aching pain and burning which radiates diffusely from the site of stinging, usually unaccompanied by edema or inflammation. Lymphadenitis usually develops. Systemic symptoms begin as a generalized numbness and throbbing, especially in the fingers and toes, followed rapidly by profuse sweating, excess salivation, difficulty in swallowing, abdominal pain, emesis, and diffuse muscle spasm. There is frequently a weak pulse, shallow respirations, marked thirst, dysuria, or even anuria. Temperature may be elevated above 40° C. Central nervous system manifestations include hallucinations, strabismus, temporary hemiplegia or monoplegia, blindness, and occasional convulsions resembling those due to strychnine poisoning.[5-11] Mild to severe myocarditis resulting from scorpion sting has also been reported.[12, 13]

In severe cases, symptoms may rapidly progress and result in death due to respiratory paralysis within one to two hours. However, most cases are not severe and the course is usually self-limited, completely remitting within 58 to 60 hours.

As can be seen, the mild local reaction produced by Isometrus maculatus does not present a serious medical problem as compared to the reaction of its more toxic relatives. It is important that physicians be aware of this so that they can with assurance allay the anxiety and fear of the patient who has suffered a scorpion sting.

There have been no reported fatalities due to scorpion stings in Hawaii—a not unexpected fact, considering the toxicity of Isometrus. However, Efrati[7] reported six fatalities in the Mediterranean areas and Stahnke[14] reported 64 deaths in Arizona from 1928 to 1948. All of the deaths in Arizona were due to the genus Centruroides.

Treatment is similar to that of most venenations with isolation of the injured part of the body by tight ligature when possible.[5-7] Ice packing of the local area is also recommended.[1, 6] The procedure of incision and suction over the site of sting is not indicated, according to most authorities. Sedatives and analgesics as needed are definitely in order. Intravenous calcium gluconate has been suggested to relieve muscle spasm and atropine to counter salivation and emesis.[14, 15] In severe cases, hydrocortisone has been used with equivocal results.[3, 14] In most instances of stinging by Isometrus, sedation and analgesia are all that should be needed. Only the very rare venenation would present any indication to use calcium, atropine, or corticosteroids.

In the treatment of the more dangerous sting of the neurotoxic species, Holmes has suggested injection of 1 gm of emetine into the site of sting for local relief of pain.[16] However, Poon-King[17] has urged caution when using this drug because of the possible deleterious effect with emetine, should myocarditis be present. Hypothermia has also been

reported to be of benefit.[18] Antivenins are the treatment of choice with the neurotoxic species but are relatively species-specific and not widely available.[4-6] Generally they are only prepared in endemic areas where serious stings occur.

The prognosis for recovery from scorpion stings is good, with the symptoms in the usual case being self-limited and of short duration. As mentioned, the highest morbidity is in young children, the aged, and the debilitated. As is often the case, young children are also the most likely to inadvertently discover a scorpion and be stung. Prevention of scorpion sting is mainly one of public health measures, awareness of the animal in the area, and appropriate precautions to avoid contact.

CENTIPEDES (CHILOPODA)

Centipedes are grotesque-appearing arthropods (Fig. 2 and 3), which are quite common throughout the world. The body of a centipede is composed of a variable number of similar segments, each of which possesses one pair of legs. The head bears one pair of long antennae and associated mouth parts, and the segment immediately behind the head possesses a pair of maxillipedes, which are used for capturing prey. At the tips of these appendages are orifices through which the venom is extruded when the centipede bites. These animals vary in the number of pairs of legs from 15 to over 100 and vary in their length from a few centimeters to over 10 inches.[1-4]

There are many species of centipedes, most of which are not dangerous to man. In Hawaii, Scolopendra subspinipes is the only species of medical significance. It is easily recognized because of the large size of adult specimens (6-8 inches). There are two other common but harmless species: Lobobius sp. and Mecestocephalos maxillaris.[4] Lobobius is a smaller, faster-moving centipede which has only 15 pairs of legs. Mecestocephalos maxillaris is a pale brownish soil inhabitant. There are no records of human bites by the latter two species. In the mainland United States, the only dangerous centipede is Scolopendra morsitans.



FIG. 2.—*Centipede—Scolopendra subspinipes. (Scale is in centimeters.)*



FIG. 3.—*Close-up view of ventral aspect of head and maxillipedes of Scolopendra subspinipes.*

The centipede venom is an opalescent fluid which is acid in reaction and only slightly miscible in water. The toxin proper constitutes only a small fraction of the total discharge from the venom glands. The main function of the venom is digestive.[3] Except for severely debilitated or very young persons, the bite of a centipede is not potentially deadly to man.

The symptoms of Scolopendra subspinipes bite are usually those of intense local pain at the site of the bite, with marked swelling. The double puncture wound is characteristic. Frequently there is lymphangitis and lymphadenitis. Occasionally there is an accompanying purpura. Some reports describe an almost unbearable pain localized to the site of bite.[19, 20] Generally the reaction is self-limited and takes its course in approximately 12 hours. There have been no reported fatalities from centipede bites.

Treatment is completely symptomatic with sedatives and analgesics as needed. Injection of

local anesthetic agents in the site of envenomization has been found to provide good relief in the cases treated at this hospital. Occasionally, compresses with sodium bicarbonate or a saturated solution of epsom salts are helpful when applied locally.[7] As in the case with scorpions, prevention is the best treatment and is best accomplished by awareness of the hazard and careful attention to avoid inadvertently placing hands and feet into dark, hidden areas when residing in an area known to be endemic to centipede.

MILLIPEDES (DIPLOPODA)

Millipedes (Fig. 4) are mentioned in passing because they are often mistaken for centipedes. They differ from the latter in that they are not venomous and each of the leg-bearing segments possesses two, rather than one, pairs of legs. As a group, millipedes are almost entirely vegetarian and their significance to man is limited to that of an agricultural pest: they do not sting. The predominant Hawaiian species are Oxidus gracilis and Trigoniulus lumbricanus. Although some species of millipedes secrete a foul-smelling fluid that can cause a contact dermatitis, this has not been reported with our local species.

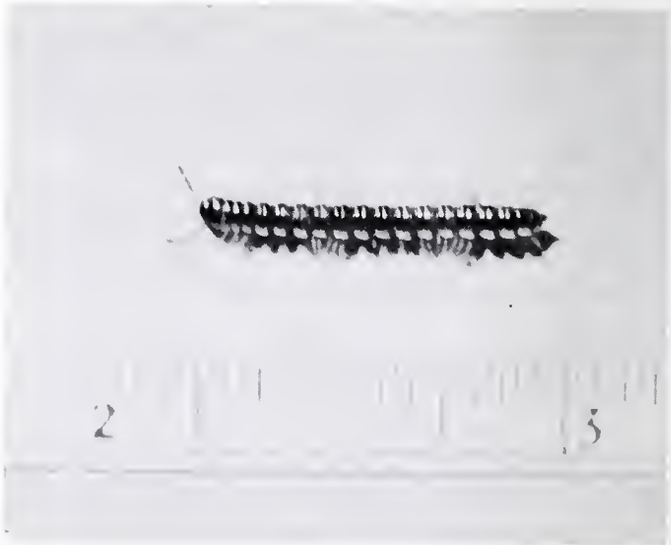


FIG. 4.—*Millepede—Oxidus gracilis. (Scale is in inches.)*

ACKNOWLEDGMENT

The author is grateful for the assistance and photographs provided by Elmo D. Hardy, Ph.D., and Albert A. LaPlante, Jr., Ph.D.

Letterman General Hospital, San Francisco.

REFERENCES

1. Faust, CE and Russell, PF: *Craig and Faust's Clinical Parasitology,* ed 6, Philadelphia: Lea and Febiger, 1957, pp. 704-710.
2. *Some Venomous Animals of the Far East,* 406th Medical Group Laboratory, Camp Zama, Japan, (1 June) 1958, pp. 11-14.
3. *Some Venomous and Noxious Animals of East and Southeast Asia.* Special report, 406th Medical Laboratory, U.S. Army Medical Command, Japan, (1 July) 1964, pp. 15-19.
4. Fullaway, DT and Krauss, NLH: *Common Insects of Hawaii.* Honolulu: Tongg Publishing Co., 1945, pp. 211-214.
5. Waterman, JA: Some notes on scorpion poisoning in Trinidad, *Trans Roy Soc Trop Med & Hyg* 31:607-624, (Apr) 1938.
6. Stahnke, HL: The L-C treatment of venomous bites and stings, *Am J Trop Med & Hyg* 2:142-143, (Jan) 1953.
7. Efrati, P: Poisoning by scorpion stings in Israel, *Am J Trop Med* 29:249-257, (Mar) 1949.
8. Mazzotti, L and Bravo-Becherrelle, MA: *Scorpionism in the Mexican Republic: In Venomous and Poisonous Animals and Noxious Plants of the Pacific Region,* a symposium volume from proceedings of the 10th Pacific Science Congress, Oxford: Pergamon Press, 1963, pp. 119-131.
9. Abalos, JW: *Scorpions of Argentina: In Venomous and Poisonous Animals and Noxious Plants of the Pacific Region,* a symposium volume from proceedings of the 10th Pacific Science Congress, Oxford: Pergamon Press, 1963, pp. 111-117.
10. Whittemore, FW and Keegan, HL: *Medically important scorpions in the Pacific Area: In Venomous and Poisonous Animals and Noxious Plants of the 10th Pacific Science Congress,* Oxford: Pergamon Press, 1963, pp. 107-110.
11. Scott, HG and Pratt, HD: *Scorpions, Spiders and Other Arthropods of Minor Public Health Importance and Their Control.* Training Guide, Insect Control Series, U.S. Dept. of Health, Education & Welfare, Public Health Service, Communicable Disease Center, Atlanta, Ga., 1959.
12. Poon-King, T: Myocarditis from scorpion stings, *Brit Med J* 1:374-377, (9 Feb) 1963.
13. Gueron, M and Weizman, S: Catecholamines and myocardial damage in scorpion stings, *Amer Heart J* 75:715-717, (May) 1968.
14. Stahnke, HL: Arizona scorpion problem, *Arizona Med* 7:23-29, (Mar) 1950.
15. Jacobziner, H and Raybin, HW: Scorpion bite poisoning, *New York State J Med* 62:2240-2243, (July) 1962.
16. Holmes, MM: Scorpion bites, *Brit Med J* 2:253, (10 Aug) 1957.
17. Poon-King, T: Treatment of scorpion sting, *Brit Med J* 1:1016-1017, (13 Apr) 1963.
18. Stahnke, HL: Hypothermia and scorpion venenation, *Southwest Med* 46:286-287, (Sept) 1965.
19. DeCastro, AB: The poison of Scolopendridae—being a special reference to the Andaman species, *Indian Med Gaz* 56:207-212, (June) 1921.
20. Remington, CL: Bites and habitats of giant centipede (Scolopendra subspinipes) in the Philippine Islands, *Am J Trop Med* 30:453-455, (May) 1950.
21. Halstead, BW and Ryckman, R: Injurious effects from contacts with millipedes, *Med Arts & Sciences* 3:16-18, (Jun) 1949.
22. Blum, MS and Woodring, JP: Secretion of benzaldehyde and hydrogen cyanide by the millipede Pachydesmus crassicutis, *Science* 138:512-513, (Oct) 1962.



CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 312, Camden, New Jersey 08101.

'here's a soup for almost every patient and diet .for every meal and, it's made by *Campbell*



The President's Page

The program for our 115th Annual Meeting is set for April 27. An excellent program has been arranged at the Ilikai and I hope to see you all there.

We are waiting impatiently for a report from Mr. Hasegawa, Director of the Bureau of Workmen's Compensation, regarding his findings after the public hearing. I hope the report will be out by the time you read this.

Medical Malpractice Insurance is now available through the Argonaut Insurance Company. This plan is endorsed by your Committee on Malpractice. The Plan requires HMA participation in the screening of applicants and adjudication of claims. Insurance is also available through a proposal from the Medical Group Management Association and the Hawaiian Insurance and Guaranty Company. Legislation has been introduced which hopefully will encourage insurance carriers to write malpractice insurance locally.

Dr. Sanazaro met with your Council at a special meeting on January 25, and the Council met again on February 12 regarding the School of Public Health's proposed Hawaii Research and Development Program for Improved Health Services. Since 1967, through your Bureau of Research and Development, your Association has been actively engaged in studying medical care in Hawaii. Because of our experience to date, the Council did not support the proposal.

John J Lowrey

Editorials

HAWAII MEDICAL JOURNAL

Health Care Delivery in Hawaii

The proposal by Dean Edward O'Rourke of the University of Hawaii School of Publie Health, to make a two-year study of health eare delivery in Hawaii and then re-establish it on a new, statewide, govcrnment-finaneed basis as a model for the nation, has been modified considerably, and merits reconsidcration.

Guidelines have now been established for such study and sueh remodeling, and submitted to the Hawaii Medieal Association in writing. By what appears to be just eoineidenee, they eonform almost word for word with guidelines enuneiated for an identieal purpose by Senator George Murphy of California in the Congressional Reeord for Novcmber 24, 1970. They are as follows:

1. Solutions should be found at the loeal level of involvement, without reeourse to federal intervention.
2. Solutions should build on progress already made, not replaee what is eurrent and good.
3. Solutions should be put into effeet one step at a time, not all at onee.

These are sensible and prudent rules, whieh we heartily endorse. If the Hawaii Medieal Association can be a full partner in the study of existing problems, as we have been in the studies by Dr. Paul Sanazaro and Dr. Beverly Payne, we should willingly participate.

The Makana Foundation for Organ Transplants

The Makana Foundation—named for the Hawaiian word for "to give freely of one's self"—has been established in Hawaii to bring together persons who wish to donate one or more of their organs, after death, for purposes of organ transplantation. The Uniform Anatomical Act legalizes such donations, and the Makana Foundation serves the essential purpose of a liaison ageney between would-be donors and needful recipients.

Incorporated last November, the Foundation has already responded to over 1,000 requests for donor application forms, and has on file 250 eompleted applications. Such applieants are given a card to carry, stating that they are Makana Foundation donors and requesting that the Honolulu Blood Bank be notified promptly in case of their demise. The Blood Bank keeps a file of donors and provides 24-hour telephone service. It also notifies physicians who are waiting to perform a transplantation operation. The recipient registry is being kept on a first-eome, first-served basis, beeause of the obvious difficulties in the way of establishing priorities.

More prospective donors are urgently needed to make this operation an efficient one: the Foundation's goal is 10,000. A larger registry of potential recipients is also desirable, of course. A call to the Blood Bank will put you on the donor or recipient registry.

The Mabel L. Smyth Memorial Building*

The attractive Mabel Smyth Memorial Building at the mauka corner of Punchbowl and Beretania Streets, catercorner from the State Capitol, provides headquarters for the professional organizations of both nurses and doctors of the State of Hawaii. So far as is known there is no other building in the United States erected through the cooperation of the nurses and doctors to house their professional organizations under one roof and to serve also as a community center for other health and related activities. Dedicated January 4, 1941, to the memory of Miss Mabel L. Smyth, an outstanding public health nurse, the beautiful building stands as a symbol of the community spirit between the local nurses' and doctors' organizations and the public.

While the need for a center for nursing activities had been discussed by the local nurses for some time, it was not until 1936 that definite steps were taken to provide such a building. About this same period the medical library, housed on the third floor of The Queen's Hospital, was outgrowing its quarters and the Medical Association was considering the possibility of making some arrangements between the library and the Nursing Service Bureau and Physicians' Exchange in order to provide longer hours of service for the library. It seemed logical that these organizations related to the associations of the nurses and doctors should be housed in one building, and the first negotiations were begun at the annual convention of the Nurses' Association in January of 1936. Dr. Douglas Bell, the president of the Territorial Medical Association, attended this meeting and proposed the cooperation of the medical and nursing agencies in order to cut down on administrative costs and provide better service to its members.

Miss Mabel Smyth served on the committee of nurses and doctors to promote this accepted recommendation. While plans were being developed, Miss Smyth died on March 18, 1936. Her contributions to Hawaii and the nursing profession had been so many and of such far reaching qualities that it became the immediate project of the doctors and the nurses to dedicate the proposed building to her memory.

The result was that five years later the modern concrete structure with its air-conditioned auditorium and attractive lounge and lanai, through the generosity of Queen's Hospital, was erected on the hospital grounds. It now serves as a focal point for meetings and other activities. People from all the islands and even from the mainland contributed to this project. The medical center of the Hawaiian Islands, it is a semi-public building available to nurses, doctors, and health and welfare organizations, as approved by the Board of Management, which consists of two registered nurses representing the Hawaii Nurses' Association, two doctors representing the Hawaii Medical Association, and one layman representing The Queen's Hospital's Board of Trustees.

The agreement between these three organizations reads that they (the associations) "do hereby guarantee to meet all expenses . . . necessary for the proper maintenance, care and upkeep" . . . "and further, not to assign or transfer their equitable interest in the use of said Memorial Wing to any other person or corporation without prior written approval of the other Association and the Hospital" . . . "and it shall be binding upon and inure to the benefit of the parties aforesaid and their respective successors."

Thus the Nurses' Association, Territory of Hawaii and the Hawaii Medical Association became the guarantors of this eleemosynary, tax-exempt building, which is not endowed.

All maintenance and other expenses are derived from office and auditorium rentals plus the income from the Nurses' and Physicians' Exchange. The Exchange gives service 24 hours a day to private duty registered nurses and practical nurses, and to doctors who subscribe to the service. Service is also given to the Medical Society through the handling of calls on their Emergency Medical Service and all calls for people attending meetings in the building.

In 1962 the Hawaii Medical Library moved out into its own beautiful building in back of the Mabel Smyth Building, and in 1966 the Bureau of Medical Economics left for more spacious quarters elsewhere. The county and state medical organizations have filled the space thus vacated.

Under the devoted and competent direction of Mrs. Illa V. "Stormy" Storme, with guidance from its appointed Board of Management, the Mabel Smyth Memorial Building is providing increasing services to Honolulu's—and Hawaii's—nurses and physicians. Let us not lose sight of its value to us, or of our legal, as well as moral, obligation to it!

* Reprinted, slightly amended, from the HAWAII MEDICAL JOURNAL for May-June, 1961.

MECO = Medical Education Community Orientation

An externship-preceptorship program for freshman and sophomore medical students, centered in rural (and some urban) hospitals and occupying 10 weeks of their summer vacation, was started in Illinois in 1969, spread to Michigan and five other states in 1970, and is now beginning in thirteen additional states, including Hawaii.

The students — one, or perhaps occasionally two to a hospital—receive room and board, and $65 to $80 a week, from the hospital. Sears, Roebuck Foundation is financing the overall administration of the program at the national level.

The gain to the community is in the likelihood that such a program will provide a powerful incentive to the student to return to it and to the hospital when he finishes medical school and is ready for practice.

Michigan's program provided this kind of training for 11 sophomore students last summer. The reports on it were strongly favorable. Bruce Fagel, the national student project director for the Student American Medical Association, which originated the project, spent part of December in Honolulu to introduce it here.

It looks sound and very much worth while. We wish it success!

Romance Never Dies

She is a tiny eighty-five, and had a hip repaired six days ago.

At night she woke up and decided she was strong enough to go to the bathroom. Of course she fell and next morning told me that: "In the midst of the night I fell on the floor and here comes this big blond young man with blue eyes and throws me on the bed like a bag of potatoes." Concerned, I asked if he had been careful. A smile broke through and she said, "O ever so tender."

The accident report read: "patient lifted into bed by two nurses and orderly."

May we always have time to "ever so tenderly" increase our facial bloodflow and tonus and acknowledge the need for romance at this age.

HERMAN P. KRAMER, M.D.

Slants and Angles

HAWAII MEDICAL JOURNAL

Death Valley Days

Over the past decade the skyline of Waikiki has come to resemble New York's or Chicago's. The astronomical price of prime land has forced developers to build multi-storied high-rise buildings to accommodate the increasing number of tourists expected to visit Waikiki in the future.

Apart from any aesthetic considerations, these tall, tightly packed buildings will effectively prevent the cooling tradewinds from blowing across Waikiki and its famous beach, creating the potential for development of what environmental engineers term a heat island. The creation of such a heat island would have far reaching consequences. Visitors come to Hawaii to be cooled by gentle breezes, not roasted alive in a stifling outdoor oven. Lying on the beach with the temperature over 100 degrees in the shade and no wind might seem more akin to an endurance contest than pleasurable relaxation. Perhaps living in an air-conditioned cubicle by day and only emerging in the open air at night might appeal to a few vacationers, but most would undoubtedly bypass Waikiki for the neighbor islands or perhaps avoid Hawaii altogether. The implications for the future economy of the State are disturbing.

Just a Few Dollars More

The Federal Government recently proposed to allocate several million more dollars to finally find the cure for cancer. This story, alas, is a familiar one which is constantly being repeated every few years. Always that last vital breakthrough lies just around the corner, just a little more basic research is necessary, just a few more dollars are needed.

Studying the masses of scientific literature being spewed forth about cancer, it is painfully obvious that more mediocre research is not the answer. Probably enough basic knowledge has already been accumulated to give us the answer to the cancer problem. What is needed now is some genius to fit the pieces together.

Contrary to popular opinion, the greatest scientific advances, the quantum leaps in knowledge, do not come from painstaking research in well equipped laboratories, but from thinkers sitting in arm chairs. Their flashes of genius and inspiration come from within and cannot, unfortunately, be produced to order or accelerated by infusions of money. Meanwhile we must endure the wasting of millions of dollars on extremely expensive, and for the most part useless, research.

The Green Tongue Syndrome

The sight of a bright green tongue is quite startling. Fortunately, the differential diagnosis is usually relatively simple, these patients being readily divided into two groups. In each group, the basic etiological factor is the same, namely, the sucking of various chlorophyll-containing preparations such as Clorets in order to sweeten and purify the breath. They are separated by determining the motive underlying their chlorophyll consumption.

The first group consists largely of shy, middle-aged ladies greatly concerned that their breath might offend the doctor. Physical examination of the nose, throat, and lung is, apart from the verdant tongue, invariably normal. Halitosis is never present and the wise physician avoids comment on his findings.

The second group is more challenging because they are trying to conceal recent alcohol consumption. Reasons for this subterfuge vary. A few, being nervous at the thought of visiting the doctor, take a few nips to fortify themselves for the coming ordeal. Some have just attended a hearty and largely liquid businessman's lunch. Many are chronic alcoholics, with tremor of the tongue and hands to confirm the diagnosis.

Whether they are motivated by concern or concealment, the mystery is why they take these pills at all. Goats eat chlorophyll all day long and their breath really stinks!

W. Philip Jones, M.D.

Inside HMA

HAWAII MEDICAL JOURNAL

The **News Media** committee is preparing a new publicity code for physicians as well as a new Code of Cooperation between HMA, the news media, and the hospitals. An attempt has been made to modernize the ethics and practices in this area, as well as to state more clearly what is and what is not permissible. Some of you may be shocked at the apparent liberality, but really, we aren't in "horse and buggy" times any more and it is time we accepted modern realities. You will no doubt be hearing more about the new codes at the HMA meeting and thereafter.

Are you aware that the old HMSA group plans pay for psychiatrist's service? There are deductibles, of course. I was not aware of this. Such a report was made to **Mental Health** in a course of discussion on what additions can and should be made to current mental health services. One question is: should the health insurance plans include payments to non-M.D.'s for care in the field of mental health? Many psychologists are extremely competent. Should they be excluded from payments simply because they are non-M.D.'s, if the M.D.'s are being paid for similar work? What do you think?

Diabetes had an interesting proposal from the Lion's Club, which wants to sponsor a year-round diabetes screening program. They have offered their services and would like to go to work under the guidance of professional people, meaning the doctors. Would you cooperate? I think it is a great idea. I do not see how anybody can possibly be hurt, and the earlier the diabetics are discovered, the better for everybody—patients, doctors, government, etc. In the program of discovery, don't drag your feet, **Diabetes Committee;** let's get the program started.

Next, **Finance** is still studying the matter of combining the HMA and HCMS retirement plans. Apparently, it's difficult. One proposal was that both plans be stopped and that we start all over from scratch. Certainly, it's time some decision was made, fellows. Haven't you been hashing it over long enough?

It is reported that Queen's Medical Center is considering breaking the 26-year lease with Mabel Smyth, and erecting a new building. It could kind of change our plans for our future needs, couldn't it? They also discussed the question of preparing a decent budget to present to the House of Delegates, when they don't know how much the House of Delegates is going to vote for various projects. Surely, there is some way of resolving this. What do the other states do? Perhaps we should place some limit on what the House of Delegates can allot in those closing moments of their annual meeting. Our public relations program has certainly suffered because of the arbitrary elimination from the budget of funds for a Public Relations Counsel.

Environmental Health is working on all the various proposals that have arisen from the ecology kick. Included are a proposed resolution requesting no smoking on interisland flights and no-smoking sections in the jetliners traveling to or from Hawaii.

Television-Radio is working on a new set for our TV shows. Dr. William Goebert is resuming the chairmanship of the **Careers** to help guide the new Health Careers Council of Hawaii, which is in the process of development.

Medical Education still favors a four-year medical school. The Department of Health is attempting to set up general practice residency programs in the Hilo Hospital and in Maui Memorial.

Sorry there is no more information, but in the last two months I have received only eight committee reports. Better luck next time.

JOHN BROWN, M.D.

Peer Review

- The *government* wants cost control.
- The *AMA* wants review by peers ONLY.
- The *people* want Cadillac care at VW prices.
- The *doctors* want to concentrate on treating the sick.

And the United States Congress has the problem of scrambling these four eggs into an omelette to suit everyone's taste.

Why do we have this problem thrust upon us? Because Medicare (Title 18) and Medicaid (Title 19) have proven to be too costly.

As Senator Wallace Bennett (R., Utah), the author of the Bennett amendment to establish Peer Standards Review Organizations (PSRO) that was passed by the lame duck session of the Senate by 48-11 on 29 December '70, put it: "The reason for a drive for a new review mechanism for Medicare–Medicaid is that we simply cannot afford to continue down the high-cost road we have been traveling. Right now, the finance committee is confronted with the unhappy task of approving a $216 BILLION tax increase to cover a potential 25-year deficit in Medicare's hospital insurance plan."

Physicians as a whole did foretell the problem of financing, and therefore resisted the inception of Medicare. In retrospect, one can say that the then Congress failed on two major counts: First, by failing to hang on to the means test as a traditional and honorable brake on the avid consumer, and secondly, by grossly underestimating the volume of the charitable services previously rendered by physicians to the elderly and the indigent and near-indigent. Once the government stepped in and assumed the financial burden, such charity was no longer proffered; no one ever feels charitable toward the government. However, this affluent country might still have been able to rise to the challenge and meet its obligations to those over 65, the above two major important factors to the contrary not withstanding, except for the expansion into Medicaid and related programs. This scuttled the ship of state. The Congress and the Nation failed to heed the age-old adage that when give-away programs are offered, the number of takers rapidly escalates.

As a result, the benefits accorded to the people by law are being withheld by regulation or seriously restricted. Patients expect quality medical care, but the mandate is for cut-rate and bargain prices—percentage payments, and with an inflated dollar, at that. As an example of the worst of this, the availability of postacute-hospital care has been lacking, and it continues to lag behind demand as the government angers and frustrates and antagonizes the owners and builders and managers of extended care facilities and nursing homes by denying their patients Medicare benefits for such necessities.

Are these restrictions and denials of benefits being presented directly to the consumers? Not at all! They receive the disheartening news that they will have to assume the financial burden themselves long afterward, through the administrator and particularly the attending physician. The latter is made the "fall guy." This onerous burden placed on the physician by the government is "softened" by means of the anonymity of a committee. The physician's peers on the Utilization Review Committee are the "bad guys," and he can tell his patient so, thus blackening the image of the entire profession to protect himself.

In spite of this, URC's in every hospital and of many medical societies and foundations have worked hard and faithfully—mostly without pay. They have done their work with compassion for both patient-beneficiary and colleague, and also with an honest attention to duty and country. The *American Medical News* of 26 October '70 in its editorial put it well: "Properly constituted peer review disciplines the erring physician, of course, but its primary purpose is to help members of the medical profession deliver the highest quality of care possible."

"There is a vast and significant difference between discipline and help," says H. L. Hartley, M.D., of Seattle in the AMN. "The emphasis by government would probably be on discipline, but that of . . . [the profession] is on help."

The government has attempted to place the blame for spiralling costs on hospitals, other facilities, and physicians. It has ignored the fact that it

is the people-patients who demand the service. It has ignored the fact that hospital UCR's rarely find an example of true delinquency. The government has blown up out of all proportion the extremely low incidence of abuse by physicians, and it is now attempting to cover up its own shortsightedness by making much of cost control via PSRO! Incredible!

The government knows:

- that there is a national shortage of physicians;
- that there is some maldistribution of physicians and services, primarily because of the exigencies of economies;
- that physicians are being overloaded by "crisis care"; and
- that, therefore, preventicare is lacking.

And yet, physicians would now be mandated—it is proposed—to sit on PSRO's, to work-over, to second-guess, to criticize on the feeble grounds of not knowing the patient, and to restrict their colleagues; to labor at constructing profiles on patients as well as on attending physicians so as to provide the Gestapo-like government with a means to whip and penalize; to be the "bad guys" in the eyes of all citizen-patients and the eyes of their colleagues. And under threat of penalty, no less!

Sure and it will be for pay! Thirty pieces of fake silver, no doubt! "Reasonable pay," says the amendment. We have had experience with that "Big Brother" term in the past. If a physician be asked to contract for onerous duties, should he not charge appropriate rates? Is not this commensurate with "hazardous duty" pay? Double, let's say? *Then* where will the costs of Medicare–Medicaid go?

The government needs to search for cost control in some other direction!

The AMA has lobbied quite effectively toward removing most of the worst restrictive elements in the Bennett amendment: (1) Pre-admission approval before hospitalization; (2) national instead of regional norms; (3) a possible $5,000 penalty for physicians who do not conform, and (4) government ownership of PSRO records. The AMA succeeded in getting modified the clause that would have permitted the Secretary, HEW, to appoint non-physicians to PSRO, so that the final amendment stipulated regional physician-appointed physicians to serve. The AMA will continue to oppose, when it comes up again in the present session, the inclusion of (a) PSRO underwriting of pilot programs at physicians' expense, and (b) physicians to perform tasks not within their professional scope on PSRO.

The AMA has had active support from Senator Carl Curtis (R., Neb.) who fought vigorously against the Bennett amendment and stated: "[Abuses of Medicare–Medicaid that have come to light] will be taken care of by government audit and by the voluntary committees in the medical associations. Given a little more time, we can write a better peer review."

The people need to learn that high quality medical care does not mean a TV in every hospital room, and that service on wilful demand, and government-financed "rest," are not a part of benefits granted by an indulgent Congress.

The doctors should continue to concentrate on treating their patients, and treating them well.

The clock cannot be turned back. Since there can be no return to a means test, and since there can be no return to charity type medical care, this nation can at least hope that there will be no extension of Medicare–Medicaid in the direction of total nationalization of health services until such time as the government figures out a way to pay for the programs that are already on the books. It might be wise to go in the direction of providing coverage for catastrophic illness only, perhaps.

We in the profession should zero in on what H. Dean Hoskins, M.D., of the Alameda-Contra Costa (Calif.) Medical Association calls: "Good utilization review: The day-to-day, prospective and concurrent, before, during, and after hospitalization [kind]. Retrospective review is a poor substitute at best."

What we physicians have long realized, and accepted with resignation and patience, is that retrospective peer review is very much like chewing one's cabbage twice over. This is now beginning to be appreciated by men like Senator Curtis, HEW Secretary Richardson, and even President Nixon himself. The President in his speech to the American Academy of Cardiology said recently: "We must keep the doctors free of the terrible pressing burden of bureaucracy." Nevertheless, peer review is something we ourselves have accepted as a factor for raising standards of medical performance. It is up to us—and the AMA—to emphasize the "help" aspect rather than the "discipline."

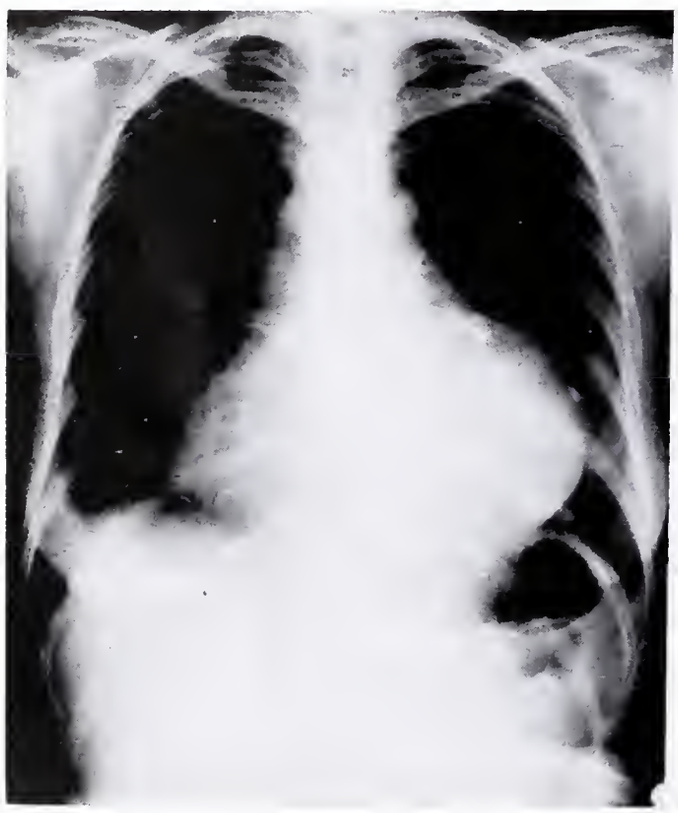
We have accepted service on hospital URC's as much as serving on credentials committees, for example. There are physician review committees in most health care insurance plans; there are medical society, county and state, committees serving extended care facilities. The Hawaii Medical Association has pioneered with a "review" of the quality and availability of health care in the state via the "Payne" study initiated in 1969 and still in progress under a Federal grant. The preliminary work and feasibility studies were done

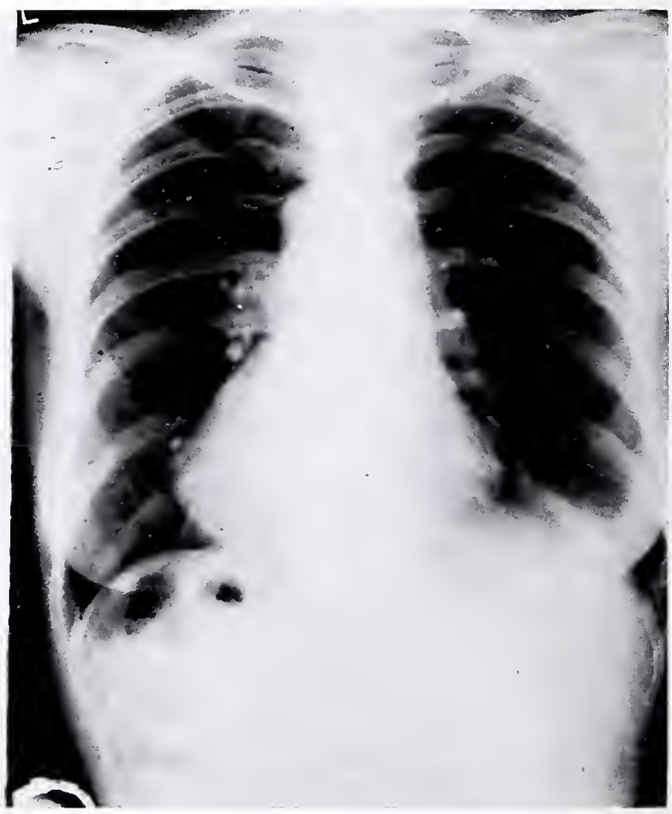
continued page 127

X-ray View Box

HAWAII MEDICAL JOURNAL

- A 58-year-old lady had had increasing exertional dyspnea for several days.
- She had had several similar episodes in the recent past which were quickly relieved by a minor procedure, and was aware of her diagnosis.
- What is it?





Answer: The patient has supraclavicular, pulmonary, and pericardial metastatic adenocarcinoma from an unknown primary in spite of careful search. Repeat pericardiocenteses had been done, with prompt relief of symptoms. A pericardial tap yielded 775 ml of fluid the same date the above film was taken, with marked relief of symptoms.

Submitted by
D. R. Grininger, M.D.
Hawaii Radiological Society

HAWAII MEDICAL JOURNAL

Book Reviews

WINFRED Y. LEE, M.D.

★Essentials of Clinical Endrocrinology

By Norman G. Schneeberg, M.D., 449 pp., $22.50, C. V. Mosby Co., 1970.

THIS VOLUME is a welcome addition to the subject of *clinical* endocrinology—a subject previously covered by a limited number of authentic texts, some of these too cumbersome to be of much practical value to a busy clinician.

This book is obviously designed for physicians who are untutored in the field of endocrinology and should prove most useful to those who desire a brief review of the pertinent clinical features, and especially treatment of the major endocrinopathies. The author has succeeded admirably in presenting the material in an easily understandable fashion—organization, style, type, and illustrations all make for rapid reading and easy assimilation of material.

Despite the cost, most family physicians and general internists should welcome it to their library.

RONALD D. MOORE, M.D.

Adventures in Medical Writing

Compiled and edited by Robert H. Moser, M.D., and Erwin Di Cyan, Ph.D., 67 pp., $6.00, Charles C. Thomas, 1970.

THESE SIX ESSAYS on various aspects of medical writing, ranging from the concise and meaty (Moser of Wailuku, Di Cyan of New York, and Walter Alvarez) to the almost too pixilated (William Bean), are well worth reading by the medical writer who would improve himself.

They also indicate that even the pros are humanly fallible. Di Cyan, who properly urges the use of short, clear words, is not above writing (in his foreword to the book) "While courses (in writing) do not castrate your divine afflatus, they will not add to your fecundity." Dictionary, anyone?

Is *data* still plural? I think so, and Moser votes 3:1 in favor of it. Bean sort of abstains from voting, by humorously offering "a data" for criticism, then saying that *data* "as a plural" is fading away, then suggesting that misuse of it (as a singular word, presumably) identifies the imperceptive writer.

I dislike *and/or;* Dr. Moser likes it; even uses it (p. 4) for *or* sometimes. I don't know how to read it aloud. But his advice, if not his example, is above reproach.

Dr. William Crosby, of Tufts, has a delightful and revealing chapter on the relationship among authors, editors, and referees. He thinks, and so do I, that referees should sign their criticisms.

Proofreading was faulty: "Avarez" in the table of contents; "noveau riche;" and "genuises" were noted in passing. But this slim, right-priced volume is one you ought to own for browsing in, if you want to improve your skill with words.

HARRY L. ARNOLD, JR., M.D.

★ means highly recommended.

Autogenic Therapy, Vol. IV: Research and Theory

By Wolfgang Luthe, M.D., 276 pp., illus., $14.75, Grune & Stratton, 1970.

THE FOURTH VOLUME in a series describing a physiologically oriented therapy which attempts to treat psychophysiological as well as purely functional illnesses.

KWONG YEN LUM, M.D.

★Progress in Medical Genetics, Vol. 7

Edited by Arthur G. Steinberg, Ph.D., and Alexander G. Bearn, M.D., 243 pp., $16.50, Grune & Stratton, 1970.

THIS SEVENTH EDITION approaches some recent advances in genetics in a most inclusive and comprehensive way. Subjects vary from basic genetic principles to up-to-date systematic discussion of specific genetic disorders. Immunology and hematology have more than their share of coverage, truly reflecting the areas of rapid advancement in genetics. References are more than adequate and almost voluminous in some chapters.

True to the controversy of our present times, the delicate subject of Chapter 7, The Legal Aspects of Genetic Counseling, is a welcome sight.

SHARON J. BINTLIFF, M.D.

The International Handbook of Medical Science

Edited by David Horrobin and Alexander Gunn, 744 pp., illus., $16.00, Putnam, 1970.

THIS NEW PUBLICATION is being offered for the benefit of the family doctor. It earns the title of "International Handbook," as it is written by multiple authors, 10 out of 18 being from the United States.

The U.S. authors are the major contributors in the first section of the book, "Recent Advances in Medical Science." The rest of the book is written almost exclusively by British authors.

Two large sections alloted to "Drugs," and the "Guide to Modern Treatment of Common Diseases," are mostly British-oriented. The book "Drug Therapy" provides similar information in a much more satisfactory way for the American physician.

To condense such a vast amount of knowledge in 700-odd pages is quite an undertaking. The first two sections deal with recent advances in medical science, including all the major specialties, basic sciences, physiology, immunology, and genetics. For completion the book deals with management of common emergencies and laboratory tests.

Personally I think the value of this book to an American physician is limited; there are many other sources with more adequate information. However, it is an excellent book for a physician who is isolated from the medical community.

continued page 127

HAWAII MEDICAL JOURNAL

Notes and News

HENRY N. YOKOYAMA, M.D.

Life in These Parts

At the annual November meeting of the Hawaii Society of Pathologists at Makaha Inn, we were astounded by the incredible ideas on delivery of health care proposed by guest speaker and Dean of the U of H School of Public Health, **Edward O'Rourke, M.D.** New HSP president **Meryl Haber** seemed to anticipate the text of Dean O'Rourke's talk as he made the following cryptic quotes: "He that sinneth before his Maker, let him fall in the hands of a physician."—Ecclesiasticus 38. After the talk: "Mr. K was distinguished for his ignorance, for he had only one idea, and that was wrong." Benjamin Disraeli. Sybil, Book IV, Ch. V (Take ye heed all, of the wisdom of the ancients).

Hideo Oshiro, a man of simple states, has an immaculately groomed light grey 1970 Mercedes coupe which is his pride and joy. Recently, he tried to avoid a 10 cent newspaper lying in his garage and smashed his front fender to the tune of $50.00. Hide becomes teary and wistful whenever he recounts the incident. Rather than continue the insufferable anguish of driving around in a sorely injured Mercedes, he rushed his beloved down to the garage for repairs next day. . . . Such is true love. . . .

Last October, proctologist **Dick Omura** slipped a lumbar disc while getting out of his car. Orthopod **Ike Nadamoto** had him hospitalized for nearly two weeks and he improved slowly on the standard regimen of bed rest, traction, and immobilization. Dick continued his painful existence for three months until haply, one day, he fell from a tangerine tree at home and landed awkwardly on one foot on a two-block cement wall. There was a fateful snap! and the pain was gone. . . . Ike refuses to endorse this unconventional form of therapy, but happy Dick contends it worked wonders. . . .

We were introduced by executive secretary **Tom Thorsen** to Ray Paschke, AMA field representative, who journeyed to these Islands to help us with our malpractice insurance problem. Apropos of the physicians' problem with insurance companies, Tom was inspired to tell us the following anecdote: A dentist, with his drill poised, was about to start on a woman patient's dental cavity. Suddenly a look of incredulity and pain came over his face, but he managed to blurt, "Madam, those are my testicles you have hold of!" Replied the woman with temerity, retaining her firm grip: "Yes, and we aren't going to hurt each other, are we?"

Catalino Cachero's 19th Hole Repertoire is legend. Unfortunately we cannot do justice to his jokes because his accent and gesticulations are irreproduceable and many of his best are unprintable. . . . "A man was worried about his heart so he went to his doctor and had an EKG. . . . He took it home and laid it on the player piano and went out to water the yard. . . . When he returned, the cardiograph was missing. . . . He asked his wife what did she do with it. . . . 'I put it on the piano,' she replied, 'and it played, Nearer My God to Thee.' "

"Have you heard about the new birth control pills for men? They put them in their shoes and it makes them limp. . . ."

"A man goes to a doctor and says, 'Doctor, I think there must be something wrong with me. My bowels move at 7:30 a.m.' The doctor examined the patient thoroughly. 'I don't know what you are worrying about. You are in excellent condition. The fact that you move your bowels regularly at 7:30 in the morning is a healthy habit.' 'I know, doctor,' the man replied, 'but I don't get up till 9:00 a.m.' "

Our scholarly editor, **Harry Arnold, Jr.,** apparently has his hangups or needs lessons on the electric typewriter. He recently turned in the following rough draft of a letter for committee secretary Heather Akana to type:

Miss Partrixia Cho
2033 Has te St
Bwerke/;ey Calif f 97 96701

Dear Mias Cho:

We are interested in -ublishjing your study pn clotting time testing, but I am returning it tp you temporar ily for you tp conasider the enclosed criticisms and suggest ions. . . .

Heather added the following postscript: "Dr. Arnold, I know my typewriter makes mistakes, but it *does* spell quite well!" (We hasten to add that perhaps it is cryptography.)

Medically Speaking

The December 30 program "Holiday Drinking" with panelists **Sister Mary Aileen, Bill Sage,** and **Robert Fisher** covered the hazards of both acute and chronic drinking. The last caller (whom we strongly suspect to be a fellow physician) effused, "I am watching your program and developed a strong thirst. . . . I am going to the refrigerator to grab myself a beer! Happy New Year!" Moderator Gordon Burke looked on bemusedly at the panelists, wondering what their reaction would be. **Bill Sage,** who had developed a powerful thirst under the glaring TV lights, declared forthwith: "I think I am going home and also have a beer from my refrigerator. . . ." **Bob Fisher,** who had been quite vocal all evening, simply smiled and was noncommittal. . . . When Gordon prodded, "Sister?" **Sister Aileen,** with her Madonna smile and delightful Catholic humor, echoed, "I think I too am going home . . . period!"

The TV committee discussed pollution as a possible topic. Chairman **Ted Tseu** (with his Tosh Togo profile) reported seeing a car sticker which said, "Remember the days when air was clean and sex dirty?"

We gathered on the front steps of Mabel Smyth for a post meeting session when **Claude Caver,** our red-haired humorist, slithered in and remarked, "You remember all that fuss when the Russians fired their ICBM into the Pacific? Why, the Eskimos have been doing that all these years and no one's made any fuss . . ." then slithered away, leaving us to decipher that one. . . .

Dialogue From Aetna Medicare Review Committee

These monthly review meetings have a certain admixture of hilarity and gravity. . . . It started as we approached the usual conference room at the Willows with the waitress eagerly informing us that everyone had ordered "Chi Chis." We discovered "Chi Chi" to be a delightful concoction of fruit juices, milk and rum served in an outsized cocktail glass shaped decorously like a virgin breast, and trimmed with a skewered piece of pine-

apple and a large Maraschino cherry. Plastic surgeon **Vic Hay-Roe,** who knows his mammary anatomy, encouraged: "You can't fly on one. . . . You have to have two, from an aesthetic point of view." While we waited for the serious session to start, we discussed the merits of the previous month's case of orbital phimosis, corrected with preputial tissue. Bob Grathwahl, our local Aetna Medicare director, remembered the improbable incident of the tissue mixup in wartime operating rooms. A patient was having a circumcision while another was having plastic repair of his eyelid. The wrong tissue got sutured to the eyelid and the final result was a "cockeyed" patient. . . . Before we recovered from this anecdote, **Henry Oyama** told us of his sobering experince with a woman patient he was about to proctoscope. She jumped off the jackknifed procto table, eyed him suspiciously and declared, "Doc, I saw exactly what happened on this kind table in a Risque Theater movie. . . ." Henry had to summon his holiest of holy expressions before she would agree to the examination. . . .

As we started on the traditional shrimp cocktails, Henry reviewed the case of a patient admitted with the diagnosis of "possible intestinal obstruction," who had remained hospitalized 12 days before having even a procto and BE done. **Niall Scully** commented, "In 12 days, it should be coming out of his mouth." We felt the last morsel of cocktail shrimp grate down our throats. . . .

Thoracic surgeon **Niall Scully** summarized the case of a 66-year-old man who had a cardiac arrest following a routine cholecystectomy. Medicare had questioned the necessity for the subsequent aortogram and the miffed radiologist wrote as follows: "An aortogram with selective arteries is an extensive study made of the large vessel arising from the left ventricle and distributing by its branches arterial blood to a specific part of the body. This procedure is done under fluoroscopic conditions." Niall commented, "Man, he's really laying it to us. His charge is reasonable, but his answer is entirely unsatisfactory." **Bill Dang** chimed: "Someone should notify him that we *are* physicians on the committee. . . ."

ObGyn man **Ted Tseu,** who was swamped with review claims, noticed that **Vic Hay-Roe** had no assigned claims and declared maliciously: "We made a motion at the last meeting that all those without claims must pay for their own dinners. . . ." Vic, with unabashed candor, retorted, "I came to make sure nothing on plastic surgery got by. . . ."

Surgeon **Bill Dang** tore into a case of a general surgeon who was attending for a patient with a posterior MI, and who had called in an internist for consultation. The surgeon had already been paid, as the attending, and the internist (who was late in submitting his bill) had not. **Bernie Fong** put up an unselfishly valiant defense for payment of both physicians. **Lup Pang,** with his sparse hair standing, demanded, "The time has come to put a stop to this sort of nonsense. What business does the surgeon have taking care of a medical case?" Whereupon Bernie admitted, "Lup, how did you guess that I was that internist?"

Tom Maeda, our affable medical consultant for Aetna, who shamelessly contends that his wife Mary makes the world's best cherry pies, reminded us that we had not ordered our usual cherry pie ala mode with two scoops of vanilla ice cream. Tom also commented that a few physicians were still not using the RVS schedule for correct coding and billing. . . . Such physicians get reviewed for overcharging in a few areas while they are undercharging in most other areas simply because they do not use the RVS schedule for reference. . . .

Conference Humor

A 45-year-old man had a craniotomy two years ago and cobalt therapy to his occiput and left lung apex for metastatic anaplastic carcinoma. He recently returned for thoracotomy and left upper lobectomy for undifferentiated adenoCa. **Quintin Uy** was curious: "Does he have alopecia?" Intern: "There is hair." Quintin: "Perhaps he has a wig?" Radiologist **Ed Quinlan:** "I've never seen hair grow after radiation therapy. Maybe the treatment was localized and he has a small patch covered by careful combing." Moderator **Noboru Oishi** offered, "How about a transplant? Will it grow?" Quintin: "Maybe it will since it's a full thickness graft." Pathologist **Grant Stemmerman,** who has ample hair and could care less about cosmetic results, was impressed with the two-year survival: "This is incredible." Noboru: "How big was the brain specimen?" Stemmy was being facetious: "Neurosurgeons are known for being delicate. Most of the material we receive is in tiny bits and unmeasurable." Neurosurgeon **Tom Sakoda** refused to be intimidated: "It is simply careful dissection. . . ."

A 57-year-old woman with metastatic breast Ca since 1968 has had radiation therapy to her breast and lymph nodes, then salpingo-oöphorectomy, further radiation to her thoracic spine, and finally bilateral adrenalectomy. She now returns with lung metastases. **Tom Fujiwara:** "Rather than adrenalectomy alone, the Sloan Kettering Institute reports better results with hypophysectomy." **Quintin Uy** concurred: "The current feeling is that hypophysectomy is superior to adrenalectomy. . . ." Neurosurgeon **Tom Sakoda** dissented: "Knowing neurosurgeons, I concur with Stemmy that adrenalectomy is safer. Mortality and morbidity may be small in hypophysectomy without disease, but neurosurgeons would rather not do a hypophysectomy. . . ." Pragmatist Stemmerman: "What are we going to do?" Noboru: "I'll try combination therapy. . . ." Stemmy: "Light touch or. . . ." Noboru: "With a yardstick measure. . . . She should be sensitive because of the adrenalectomy. . . ." **Tom Fujiwara:** "But if you don't get toxicity, you don't get results. . . ." Noboru: "I don't think that is necessarily true. . . ." Stemmy: "I'm personally happy I don't need combination therapy in the next two months. . . ." Noboru: "I'm glad you qualified it by saying the next two months. . . . Who knows?"

A recalcitrant 64-year-old man with undifferentiated adenocarcinoma probably of the prostate, with metastasis to the rectum, signed himself out of Memorial Hospital after three days, refusing all forms of therapy. Urologist **Masaru Koike** complained, "You don't know this man. . . . He's mad at doctors and all surgeons in general. . . ." **Quintin Uy:** "Perhaps he needs a head transplant." Stemmy: "He's probably smarter than all of us. Patients have an intuition, you know." ENT man **George Kimata:** "He's a hard head bugga. . . . This is the kind of patient who you wish would go elsewhere. . . ." Moderator Noboru: "Well, anyone for palliation?" No takers. . . .

At a Queen's medical conference, neurologist **Ronald Yamaoka** discussed the effects of L-Dopa, using data from fellow neurologist **Mike Okihiro's** series. Medical Education director **Jim Orbison,** whose top has become appreciably sparse in recent years, asked hopefully: "Will you comment on the change in hair color? A friend of mine claims his white hair has turned black." Ronald: "Well, Japanese doctors are even reporting hair growth." Jim: "Are there other rejuvenatory qualities? Not that I have any personal interest, you understand. . . ."

Victor Nelson discussed atypical mycobacteria and categorized them into atypical and non-atypical groups. **Doug Bell Jr** wondered about the vague terminology: "Non-atypical?" **Bob Jim** felt, "Perhaps it should be atypical-atypical."

Visiting pediatric professor **John Kenwood,** from Child Psychiatric Hospital, Chicago, lectured on "Advice and Reassurance." When he concluded, **Duke Choy** asked, "What's your feeling about pacifiers?" John: "I have no strong feelings. . . . What's the practice in Hawaii?" Duke: "It is particularly prevalent in military families with their emphasis on discipline and so forth, you know. . . . I have been on a personal campaign to eradicate pacifiers from the Islands." John: "How about thumb sucking here?" Whispered our knowledgeable **Don Marshall,** "That's nature's pacifier, you know. . . ."

continued page 122

In Memoriam—Doctors of Hawaii

HAWAII MEDICAL JOURNAL

This is the eighty-ninth installment of In Memoriam—Doctors of Hawaii.

Thomas Price Tisdale

Thomas Price Tisdale was born in Vittoria, Norfolk County, Ontario, Canada, in 1830. As a young man he left Canada and settled in the state of New York, and in 1858 he graduated from Cleveland University of Medicine and Surgery. Prior to coming to Hawaii, Dr. Tisdale practiced in Elmira, New York.

Dr. Tisdale was married and the father of four children: Dyo Lewis, who died in 1898; Dr. Charles Lewis; Mrs. Louise T. Smith; and Mrs. Edwin Pond James.

In October, 1877, ill health brought the doctor to Hawaii to see if a winter in a mild climate would prove beneficial, and, by the following April, he was writing to friends in Elmira that his health was much improved and that he and his family had spent a delightful winter in Honolulu.

Deciding to remain in the Islands, Dr. Tisdale opened an office in January, 1878, at the Hawaiian Hotel, where he was then residing. An article about the doctor in the *Advertiser* of January 5, 1878, says that he is a homeopathic physician of some 20 years' experience and specializes in diseases of the nose and throat, incipient consumption, affections of the kidney and bladder, and the diseases peculiar to women, and adds that he is provided with a complete set of modern instruments and apparatus for the treatment of these maladies. Then follows a note to the effect that particular attention is given to the treatment of children. In May Dr. Tisdale was joined by his son, Dr. Charles L. Tisdale, just graduated from Hahnemann Medical College in Chicago.

In November, 1879, Dr. Tisdale formed a partnership with Dr. Lyman Thompson of Kohala, Hawaii, to lease all the property of the Halawa Sugar Company in Kohala for a term of five years. Meanwhile, the younger Dr. Tisdale had moved to Kohala and was apparently also interested in the sugar company.

Dr. Tisdale and his family left the Islands in July, 1883. They were reported to be "homeward bound for Canada," but located in Oakland, California, where the doctor opened an office. After five years in Oakland, he moved to Alameda, California, and practiced medicine there until 1913 when Mrs. Tisdale died and he retired.

Dr. Tisdale died in Alameda on May 10, 1918, at the age of 88.

Charles Lewis Tisdale

Charles Lewis Tisdale, son of Dr. Thomas Price Tisdale, was born about 1858 in Auburn, New York. In 1878 he graduated from Hahnemann Medical College and Hospital in Chicago.

Following graduation Dr. Tisdale arrived in Honolulu aboard the "City of New York" on March 30, 1878, to join his father in the practice of medicine. By 1879 he had located in North Kohala, Hawaii, where he practiced and had an interest in the Halawa Sugar Plantation, which his father and Dr. Lyman Thompson had leased for five years. In the 1880-1881 Hawaiian Directory he lists himself as M.D. and Sugar Planter. He seems to have found some time for less serious matters, and in December, 1879, played on a baseball team representing the young men of Kohala against a team from the outside. Although "Dr. Tisdale pitched in fine form throughout the game," the outsiders won with a score of 14-10.

The exact date of Dr. Tisdale's departure from the Islands is not known, but in his obituary in the *Alameda Times-Star* the year is given as 1887. In any event, he settled in Alameda, California. Shortly thereafter, he went to "Scholarrie" (probably, Schoharie), New York, where he married his wife, Emma. Three daughters were born to the Tisdales: Deane (Mrs. Edward L. Varney), Ruth (Mrs. John Parker), and Dorothy (Mrs. Paul Gardiner).

From 1887 to 1906 Dr. Tisdale was in general practice. In 1905 he began serving as secretary of the California State Medical Board, a position he held for 20 years. From 1906 to 1914 he was coroner of Alameda County and discontinued his private practice. At the conclusion of his eight years as coroner, Dr. Tisdale did not return to private practice but became interested in a number of business enterprises and was also working on a treatment for cancer. At one time he was a mem-

continued page 129

County Society News

HAWAII MEDICAL JOURNAL

Hawaii

The January 21 meeting was held at the Hilo Hotel. Mr. Paul Brumage and Mr. Robert Chase, faculty members of the University of Hawaii, with Dr. DeWitt Smith presented an interesting panel discussion regarding population increase and related problems. Some emphasis was given on problems particular to the Hawaiian Islands. Following the discussion a short business meeting was held.

Dr. Paul Caldwell asked that the County Medical Society support Police Chief Fergerstrom in enlarging the vice squad on our island. A vote was taken which would support the stand.

* * *

Nineteen members and guests attended the February 18 meeting.

Dr. John Lowrey, current Hawaii Medical Association President, and Dr. Herbert Chinn, president elect, opened the discussion by stressing the importance of the State Medical Society which is expected to play a leading role in peer revue in the future.

Dr. Nicholson and Dr. Warshauer then gave a detailed talk regarding the published Relative Value Scale. Mr. Tom Thorson talked of malpractice insurance in Hawaii and a new plan which will be offered to Society members beginning immediately.

One new member was introduced: Dr. Tadao Nagashima. Dr. R. P. Wipperman was elected as executive secretary of the Hawaii County Medical Society. The library committee will be asked to arrange for the distribution of audio digest teaching cassettes to other hospital facilities; presently they remain at Hilo Hospital. The executive committee has been asked to renew our subscription for the Heart Fund booklet which is received monthly by the Society. It is purchased at minimal cost.

Mr. Tom Thorson then spoke to the members of the executive committee on matters relating to malpractice insurance.

Honolulu

Approximately 310 members were present at the annual meeting and election on December 1.

Dr. Omura announced the rules for election. He stated the polls would close at 8:00 P.M. There was one correction on the ballot: the membership should vote for six Board of Governors instead of five, and the member receiving the lowest number of votes would fill the one year unexpired term of Dr. Botticelli, who has resigned from the Board. The Secretary will cast the vote of the Society for the following unopposed offices: Secretary, Treasurer, Board of Censors, and Alternate Delegates to HMA. Tellers for the election would be Dr. Andrew Morgan, chief teller; Drs. Rodney West, Bernard Fong, Masaru Koike, and Victor Hay-Roe.

Dr. Millard asked for a moment of silence in the memory of Dr. John Stephenson who died on November 16, 1970.

Dr. Omura stated there would be no increase in Society dues for 1971.

The membership was invited to attend a symposium and special telecast on Levodopa in the Treatment of Parkinson's Disease, to be held at Tripler Army Hospital, December 17 at 7:30 P.M.

The membership approved a motion to accept the 1970 annual reports of the Society as circulated.

Mrs. Jerome Tucker, outgoing president of the Woman's Auxiliary, reported on the Auxiliary's activities for the past year, and presented the new president, Mrs. Richard K. B. Ho, who introduced the rest of the Auxiliary officers for 1971. They were Mrs. R. Frederick Shepard, President-Elect; Mrs. Robert G. Benson, Vice President; Mrs. Robert T. S. Jim, Recording Secretary; Mrs. John McDermott, Corresponding Secretary, and Mrs. Shigemi Sugiki, Treasurer.

Dr. Omura referred to his President's Report published in the Society's Annual Reports. He stated that the AMA's Speakers Seminar that was conducted this year will be back every three years and he hoped the doctors would take advantage of it as it was a very worthwhile endeavor. On behalf of the Society, Dr. Frissell presented to Dr. Omura a plaque in recognition of his leadership as president.

Dr. Edward O'Rourke, Dean of the School of Public Health, University of Hawaii, presented a review of a proposed study to be made by the School of Public Health, of the Delivery of Health Care Service in the State of Hawaii. Dr. O'Rourke stated that he would have copies made of his proposal to circulate to the entire membership.

Results of the election were announced by Dr. Morgan as follows:

President-Elect: Winfred Y. Lee
Secretary: William W. L. Dang
Treasurer: Elmer C. Johnson
Board of Governors: Charles T. H. Ching, Albert Chun Hoon, Francis T. Oda, Michael Okihiro, Coolidge S. Wakai, and Patrick J. Walsh
Alternate Board of Governors: Ann B. Catts, Henry H. C. Fong, H. William Goebert, Jr., and Thomas K. S. Lau
Board of Censors: Richard S. Omura
Medical Practice Committee: H. William Goebert, Jr., Robert Oishi, and Arthur Sprague
Nominating Committee: Chew Mung Lum and Henry N. Yokoyama
Delegates to HMA: Frederick A. Dodge, Richard K. B. Ho, Philip H. F. Watt, Calvin C. J. Sia, Henry H. L. Yim, Arturo F. Slacedo, Benjamin C. K. Tom, Frederick Warshaeur, and Niall M. Scully
Alternate Delegates to HMA: Clifford B. G. Chang, Robert Nordyke, Edward L. Chesne, Raymond M. DeHay, Richard T. Mamiya, Winfred Y. K. Chang, Alvin A. C. Paraz, Hing Hua Chun, Ann Barbara Ho Yee, Cora L. Au, Edwin R. Ballard, Roy M. Kaye, Robert Oishi, James G. Bennett, Anna Maria Brault, Norman Goldstein, T. Roy Kaku, Cesar DeJesus, Arthur K. Wong, Willard Y. Miyahiro, Charles T. Ching, William G. Davis, Carl E. Johnsen, Richard K. S. Pang, Raymond M. Tamura, Richard P. Tesoro, and William H. Sage

Dr. O. D. Pinkerton conducted the installation of the new officers and was given a vote of thanks by the

continued page 120

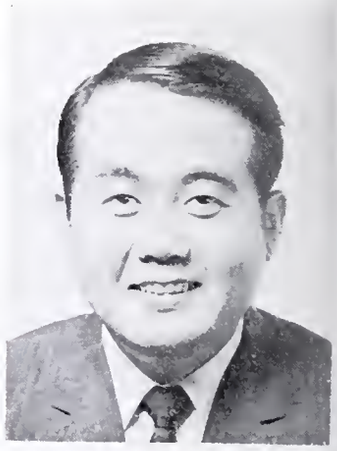
New Members



Barry D. Miller, M.D.
888 South King Street
Honolulu, Hawaii 96813
GENERAL PRACTICE
Georgetown University—1968
Internship—St. Francis Hospital,
Honolulu—1968-1969



Charlotte M. Florine, M.D.
691 Alexander Young Bldg.
Honolulu, Hawaii 96813
PSYCHIATRY
University of Iowa—1943
Internship—Queen's Hospital—
1944-1945
Residency—Western Psychiatric
Institute & Clinic—1963-1966



Wayne S. Takemoto, M.D.
839 South Beretania Street
Honolulu, Hawaii 96813
OBSTETRICS-GYNECOLOGY
Indiana University—1962
Internship—San Diego County
Hospital—1962-1963
Residency—UCSD University
Hospital of San Diego County—
1965-1969



Robert T. Maehara, M.D.
2547 Ala Wai Blvd., Apt. 101
Honolulu, Hawaii 96815
ANESTHESIOLOGY
Stritch School of Medicine of
Loyola U.—1965
Internship—Queen's Hospital—
1965-1966
Residency—UCLA Medical Center—
1966-1970



Joseph Judson McNamara
888 South King Street
Honolulu, Hawaii 96813
THORACIC SURGERY
PEDIATRIC SURGERY
Washington University School of
Medicine—1961
Internship—Peter Bent Brigham
Hospital—1961-1962
Residency—Peter Bent Brigham
Hospital—1963-1964
Children's Hospital Medical Center—
1962-1963
Massachusetts General Hospital—
1964-1966
Children's Hospital Medical Center—
1966-1967



Donald Joseph Huber, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
ORTHOPEDIC SURGERY
St. Louis University School of
Medicine—1963
Internship—Veterans Administratio
Los Angeles—1963-1964
Residency—U.S. Public Health
Hospital, Staten Is., N.Y.—1966-196
San Francisco Orthopedic Program-
1967-1970



Gerald T. Alexander, M.D.
Varsity Bldg., Suite 503
1110 University Ave.
Honolulu, Hawaii 96814
PSYCHIATRY
University of California at Los Angeles—1965
Internship—Memorial Hospital, Long Beach, Calif.—1965-1966
Residency—Queen's Hospital & Mental Health Clinic—1966-1969



William E. Miller, M.D.
888 South King Street
Honolulu, Hawaii 96813
INTERNAL MEDICINE
Jefferson Medical College—1963
Internship—Lankenau Hospital, Philadelphia, Pa.—1963-1964
Residency—Cleveland Clinic—1964-1968



John H. Davis, M.D.
4721 Kahala Avenue
Honolulu, Hawaii 96816
CARDIOLOGY
University of Southern California—1943
Internship—L.A. County & U.S. Navy—1941-1942
Residency—U.S. Navy, Oakland, Long Beach, Mare I.—1943-1945



D. Venu Reddy, M.D.
4614 Kilauea Avenue
Honolulu, Hawaii 96816
PEDIATRICS & PEDIATRIC CARDIOLOGY
Osmania Medical College—1957
Internship—Fairview Park Hospital, Cleveland, Ohio—1958-1959
Residency—University Medical Center, Columbia, Mo.—1959-1961
Fellowship—Pediatric Cardiology, UCLA Medical Center—1961-1964



Robert F. Lindberg, M.D.
888 South King Street
Honolulu, Hawaii 96813
ORTHOPEDICS
Cornell University Medical College—1961
Internship—Hitchcock Hospital, Hanover, N.H.—1961-1962
Residency—Hitchcock Hospital, Hanover, N.H.—1962-1963
Tripler General Hospital—1964-1967



George W. Starbuck, M.D.
226 N. Kuakini Street
Honolulu, Hawaii 96817
PEDIATRICS
University of Vermont College of Medicine—1938
Internship—St. Francis Hospital, Hartford, Connecticut—1938-1939
Residency—Boston City Hospital—1939-1940
Children's Medical Center, Boston—1941 and 1945

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

February 12, 1971 — 5:00 P.M.
Mabel Smyth Conference Room

PRESENT

John J. Lowrey, presiding; Drs. Chinn, Dang, Frissell, Helms, Iaconetti, Mills, Miyashiro, Sloan, and Tomita, plus Drs. Goto, Lee, Pavel, Reppun, Sia, Sowers, Stewart, Wakai, and Watson, Mr. V. Thomas Rice, Mrs. Betty Lawson, and Mr. Ray Paschke (AMA Field Representative).

MINUTES

ACTION:

It was voted to approve the minutes of the December 11, 1970, meeting as circulated.

COMMUNICATIONS REQUIRING ACTION

Correspondence from SAMA: The Student American Medical Association is requesting the HMA to sustain its membership by contributing $100.00. It should be noted that these membership dues enable SAMA to carry out its programs in medical education, community health, international health, and medical trends and legislation.

ACTION:

It was voted to contribute $100 to SAMA by way of the Hawaii Chapter.

Correspondence from AMFAC: Mr. Don Nicholson, Vice President Director of Industrial Relations, of AmFac has requested the HMA's position in relation to the Makana Foundation. The Makana Foundation has to do with "organ Banks."

ACTION:

It was voted that the HMA go on record as endorsing the Makana Foundation.

REPORT OF THE SECRETARY

ACTION:

It was voted to approve the Secretary's report.

REPORT OF THE TREASURER

ACTION:

It was voted to approve the November 31 and December 31, 1970 balance sheets subject to audit.

REPORT OF THE COMMISSIONS AND COMMITTEES

Commission on Education and Scientific Research: The report was circulated, reviewed, and discussed. The following recommendation was made: (1) That Council approve the Medical Education Committee's recommendation to support the development of a four-year medical school at the University of Hawaii and to support the concept of using community hospitals as teaching hospitals.

ACTION:

It was voted to support the development of a four-year medical school at the University of Hawaii, and to support the concept of using community hospitals as teaching hospitals.

The Council recommended that HMA write Sen. F. Wong and Rep. R. Kimura re this matter.

Commission on Internal Affairs: The report was circulated, reviewed, and discussed. The following recommendation was made: (1) That Council approve the general theme of "Pathology as it Relates to Clinical Practice" for the 1972 Annual Meeting.

ACTION:

It was voted to approve the Commission on Internal Affairs' recommendation.

Commission on Medical Services: The report was circulated, reviewed, and discussed. The Commission did not have recommendations to Council; however, there was considerable discussion about the Department of Social Services' budget. It was reported that the Indigent Medical Care Committee met with Mr. Robert Millar and Dr. Alice Dahlby of the DSS on February 1, 1971, at which time an exchange of views was had relative to that part of the budget asking for an increase of funds to provide for increased physician fees. The Committee was informed that several hearings had already been held and that representatives from the HMA did not attend these hearings to express their feelings re the need for an increase of physician compensation.

It was reported that the Senate Committee on Human Resources, chaired by Sen. Toyofuku, held a hearing re the DSS budget. It was at that meeting that it was learned that the Governor had deleted the increased physician compensation from the budget. The budget submitted is for the years 1971-1973. The Council was informed that the HMA was deprived of information relative to the deletion of "increase of physicians' fees" from the budget, and that HMA was not informed and therefore did not attend to give testimony at the recent hearing.

ACTION:

It was voted that a letter be sent to Senator Toyofuku expressing the HMA's concern relative to the DSS budget and especially to that portion of the budget where the increase of physicians' fees was deleted.

(Note: Dr. Lowrey later attended a DSS budget hearing and gave testimony.)

Commission on Legislation: The report was circulated, reviewed, and discussed. The following recommendations were made:

(1) That Council approve the proposed position statement on generic drugs as recommended by the Pharmacy Committee. After reviewing the statement, it was recommended to substitute the word "concern" for the word "interest" as it appears in the first paragraph.

"The Hawaii Medical Association has an inherent concern in the use of drugs as important tools of the medical profession. The Association's concern is in their quality, cost, and the methods and control of their distribution and administration.

The Association recognizes that there are highly reputable producers of brand name drugs and equally reputable producers of general name drugs, and

continued page 132



the name dropper

Name dropping is the practice of identifying with greatness. How many of these great names can you drop?
(Answers are in column at left.)

One name you'll have no trouble with is Neo-Synephrine. For ENT examinations, Neo-Synephrine 1% drops have been so dependable for so long—over 30 years—that they are synonymous with "nasal decongestant."

With Neo-Synephrine, nasal passages open quickly for examination and initial therapy. Then, for continued effective treatment at home, the many available dosage forms and strengths of Neo-Synephrine allow you to choose medication specifically for congestion of all stages, for noses of all ages. So well tolerated by delicate respiratory tissue, Neo-Synephrine is recommended even for infants (⅛%) and children (¼%).

Top Row: (l. to r.)
Andrew Jackson
Ulysses S. Grant
Joseph Lister
Sitting Bull

Middle Row: (l. to r.)
Carrie Nation
Benjamin Disraeli
Catherine the Great
Rembrandt

Bottom Row: (l. to r.)
Susan B. Anthony
Booker T. Washington
The Name Dropper
George Washington

Neo-Synephrine® HCl

brand of phenylephrine HCl, USP

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (1475M)

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: BETTY BELL, *Vice President:* NOEL EVANS, *Secretary:* NOLAN HASEGAWA, *Treasurer:* RICHARD HORI, *Board of Directors:* C. CACHERO, H. T. CHEE, B. CHOCK, E. ELKE, F. FRICK, R. NAITO, W. OGOMORI, J. TARASAWA, A. YEE, C. YEE.

The President's Corner

STATIC NECROSIS

What can we do with what we know? We can build on our strengths and bury our weaknesses. The essence of the profession of pharmacy is in its practice, not in theory or the fact of educational degrees. The real test is integrating our learning into positive action—managing ourselves, our business, our families, our communities, our government, and our faith.

Perhaps it's time *we* pharmacists undertake a personal audit. How do we stack up as personal managers? Are we still practicing professional isolationism satisfied to maintain the status quo, avoiding new undertakings, delaying expansion of needed facilities or afraid to stick our necks out—double talking ourselves out of managing our personal lives or our business responsibly. If you can answer yes to any one of the above, you and our profession have very serious symptoms of decay, or maybe we should coin a new disease, "static necrosis" of a time-honored profession.

Now is the hour of decision. I challenge each one of you to *act* for the good of our profession and your own personal gratification. What do we want for our profession—what is the broader vision for continuity of our own professional growth? Is the dollar your *goal?* Sure, partly, but more importantly, our goal is our personal quota of achievement in service to our fellow man via the profession of pharmacy, our service clubs, our churches, and our families.

Just as the whole is made of many parts, so is the profession of pharmacy. It is as strong as our weakest disinterested practitioner. Let's practice the golden rule, inter- and intraprofessionally, and rise up to what we are, "a time honored profession making a meaningful contribution to the medical care team in the interest of the public health."

I am encouraged by the recent response of Hawaii pharmacists to our licensing questionnaire.

As a profession, we must know what we want, develop the right climate to achieve our objective, then act positively and knowingly to accomplish our goals.

You have told the Association what you want in relation to licensing legislation. It is now up to us, with your support, to develop the climate to achieve your objectives and act to effect new legislation.

For your collective information, the majority selection for the development of statutory changes are as follows:

1. Present licensing laws disadvantage the State of Hawaii from recruiting the best pharmacy graduates and prevent our own youth from returning to Hawaii to practice.
2. Hawaii should reciprocate licensure from other States meeting National Board Standards but reserve the right to examine each applicant on Hawaii Law pertaining to the practice of Pharmacy and his practical application of the art as well as his professional judgment.
3. Applicants shall be able (eligible) to write the Hawaii State Board Examination upon graduation from an accredited college of pharmacy and completion of an internship of recognized quality and length as defined by the standards established by the AACP & NABP.
4. Temporary licensure will be granted to applicants qualified to write the Hawaii Board Examination upon evaluation of the applicant's professional judgment by a member of the Hawaii State Board of Pharmacy. Such licensure will only be valid until the first regularly scheduled exam is given.
5. All pharmacists licensed in the State of Hawaii shall maintain their right to renew their licensure through active participation in continued pharmaceutical education endeavors. Criterion is to be drawn by the Hawaii State Board of Pharmacy. (There shall be no exceptions—out of State licensees, retirees, or whatever.)

We will endeavor to fulfill *your* directive—but you too have an obligation to fulfill, to present testimony when asked, and to work with your respective legislators to assist their understanding of the importance of good licensing laws and continuing educational goals for pharmacists in support of our role in the dissemination of correct factual information on drug abuse and health care criteria.

Lend us your ears, your eyes, and your thoughts. Call your legislative committee: Wilfred Ogomori, Glenn Pang and Omel Turk, or write to the Association Secretary, Gwen Baer.

MARK YOUR CALENDAR TODAY

15th Annual D.D.D. Golf Tournament
Thursday, April 22, 1971
Francis Brown Golf Course
Dinner: Rainbow Gardens
RICHARD YOSHINO, *Chairman*

NEWS OF OUR COLLEAGUES FROM THE ALOHA COMMITTEE

The Nolan Hasegawas have been blessed with a baby girl; the George Crawfords with a baby boy.

PHARMACY LOSES A VALUABLE COLLEAGUE

Mr. Naonobu Yoshino, RPH, came to Honolulu from Japan in 1906. His pharmacy career in Hawaii was initiated at Hawaii Drugs and Benson Smith. Then he went on to Kauai where he opened his first pharmacy, "Yoshino Drugs" in 1927. Kauai enjoyed the contributions of Mr. Yoshino until 1954. Moving to Oahu he opened Value Drugs, now extended to a three store chain and shared by the efforts of his son, Richard.

Mr. Naonobu Yoshino retired in 1965, leaving an impressive contribution to the heritage of Pharmacy in Hawaii and an ongoing pharmaceutical practice in the hands of his capable son, Richard.

Our collective condolences to Richard Yoshino and the family of Mr. Naonobu Yoshino.

Board of Directors Meeting

Mr. Noel Evans announced that Dr. Ronald Pion would have an informal question and answer period at the Family Planning Seminar scheduled for Monday, January 11, 1971.

Mr. Henry Ursahima reported that the next quarterly meeting will be sponsored by the Medical Service representatives on February 24, 1971 at Tripler Hospital's Officers Mess, 6:30 p.m. Dr. George Mills will speak on legislation of interest to the medical community.

Mr. Omel Turk, Chairman of the April 2-5, 1971 Hawaii Pharmaceutical Association Convention at the Princess Kaiulani Hotel reported on finalization of plans. A $1,000.00 donation has been received from the American Cancer Society to assist in acquisition of outstanding speakers in the area of Cancer Chemotherapy. A second day will be devoted to the subject of Family Planning. Mr. Turk commended the University of Hawaii's continued education section for their tremendous support of our efforts. A representative from H.Ph.A. to the A.Ph.A. Convention in San Francisco will be selected at the February 24, 1971 quarterly meeting.

Mr. Sidney Kosasa, Chairman, Retail Druggist Committee, suggested the American Druggist Counterdose chart be published in our local newspapers under the sponsorship of the H.Ph.A. The Executive Secretary will seek permission from the American Druggist for publication.

Mr. Clarence Yee, Chairman of the Poison Prevention Committee, is circulating a letter to the membership indicating the availability of poison antidote kits for distribution through pharmacies to their customer families during "Poison Prevention Week" Letters to physicians and announcements in newspapers will afford wide publicity for this program.

Mr. James McElhiney, Chairman of our Drug Abuse Committee, follows his establishment of the "PRN," Pharmacists Reporting Network, a contact mechanism for advising all pharmacists on Oahu of individuals seeking inappropriate utilization of prescription drugs over the counter drugs, and those attempting forgeries with continued vigor. Mr. McElhiney ably represents the Association on Hawaii's Committee on Drug Abuse and served as our representative to the International Narcotic Conference held in Honolulu, October 1970. This committee welcomes your interest and ideas in order that they may set priorities for dissemination of information that will most assist your role as a Drug Abuse Information Specialist.

Legislative Committeeman, Glenn Pang, advised of the meeting held with the Board of Pharmacy. The results of the information questionnaire on licensing circulated to our membership was presented as a cooperative guideline for comprehensive study and statute changes. The Board bill to recognize internship acquired in other states will again be supported by the Association, hopefully the beginning of meaningful research and cooperation in the development of effective legislation in the interest of pharmacy and the public health. The Committee, with the approval of the Board of Directors, have acquired the services of the Legislative Information Center.

Career Day Chairman, Edmund Ehlke, announced the successful participation of the Association. An ever increasing number of individual students indicate their interest in pharmacy each year. Our thanks to Eli Lilly for providing a beautiful exhibit, "Friend of the Family," and certainly to James McElhiney, Loren Wong, Jimmy Asato and Noel Evans for their time and considerable efforts.

The Election Committee Chairman, Alice Yee, announced individuals selected for next year's slate of officers and asked for suggestions. Nominations will be sought from the floor at the quarterly meeting.

The Tax Exempt Status of the Association is being pursued with clarification of our 1969 financial statement.

Correspondence with H.M.S.A. Executive Vice President Veltmann, requesting representation of the profession of pharmacy as a member of their Board or via a Peer Review Board, has been accepted. Mr. H. T. Chee has been appointed chairman of the H.M.S.A. Peer Group Review Committee. Please advise Mr. Chee of your views on the H.M.S.A. pharmacy form utilized for title XIX and their private insurance plans. I'm sure he'll try to assist in solving any communication or misunderstandings between pharmacists and H.M.S.A.

The Association has been asked to provide a group medical insurance program for our membership. Mr. Walter Nakama of H.M.S.A. presented an outline of their group plan #4 at our February 12, 1971 meeting. In order to accomplish the greatest good for the greatest number of our membership, a comparative analysis of H.M.S.A.'s several plans will be made in order that each employee and/or employees may decide whether he might benefit from a plan able to utilize a larger base as the Association could provide. A letter will be circulated to each member.

Mr. Richard Botti, Divisional Manager of the National Federation of Independent Business, spoke to the Board at their January meeting. A note of special interest to our membership might be his comment of a Small Claims Court: in operation in Hawaii, January 1, 1971. Small Business may take individuals to court on a $300.00 or less claim at no cost. Claim forms are available at the District Court. Mr. Botti was invited to assist our legislative committee. He accepted.

Interactions of Oral Coumarin Anticoagulants

TABLE 1.—*Drugs Reported Potentiating the Effects of Oral Coumarin Anticoagulants*

DRUG	MECHANISM OF ACTION
Anabolic Steroids (Nilevar) Durabolin d-Thyroxine Thyroid	Unclear. May cause an increased affinity of the receptor site for the coumarin anticoagulants.
Atromid S Dilantin Butazolidin Tandearil Salicylate Compounds Indocin	Probably due to displacement of the anticoagulant from the protein binding sites in plasma. Increase peak plasma concentration of free coumarin and prolongs its plasma half life.
Antabuse Ritalin Analexin	Inhibits hepatic microsomal enzymes needed for metabolism of the coumarin anticoagulants. Slows the rate of disappearance of coumarin from plasma.
Chloromycetin Neomycin Gantrisin Tetracycline	May prolong prothrombin time by interfering with Vitamin K production by gut bacteria.
Tylenol Methylthiouracil Quinidine Quinine X-Ray	Not Established

continued page 126

membership. Dr. Omura presented the gavel to Dr. Frissell. Dr. Frissell asked for the membership's thoughtful consideration on matters of economic and political nature which may tend to divide the Society, and stated that the Society should face these problems as a cohesive body.

* * *

Approximately 90 members attended the January 5 meeting. New members introduced were Drs. Gerald Alexander, John H. Davis, Charlotte M. Florine, and Donald J. Huber.

Mr. Thorson presented a brief picture of the present malpractice insurance situation. He stated that we are now engaged in reopening negotiations with Hawaiian Insurance & Guaranty and the prospects for coverage are reasonably bright. We are also preparing legislation that may release some of the strained stress that insurance companies undergo in the malpractice field. There are some 350 doctors who will be faced with the problem of not having their malpractice insurance renewed. We hope the answer to this is going to be forthcoming within the next two weeks. The probability of having an ongoing program of malpractice insurance is pretty good. We are looking to the insurance companies and possibly HIG for a long term plan for participation by the doctors.

Mr. Thorson reported that the AMA Speakers Training Program will be back this September. He referred to Dr. Omura's comments made at the annual meeting that he hoped the doctors would take advantage of this opportunity to participate in a worthwhile program.

Speaker for the evening was Senator David C. McClung, President of the State Senate. His topic was, "The Legislative Process," an enlightening discussion of how a bill is introduced, until its final passage or veto, as well as the operation of the government in Hawaii. Following his presentation, Mr. McClung answered questions from the membership.

Before adjourning the meeting Dr. Frissell asked the membership to read carefully the letter from Dr. Lowrey and the report submitted by Dr. Edward O'Rourke that was circulated to the membership. The members of the Board of Governors held a special executive session of the Board following the meeting of the Society.

* * *

Approximately 129 members were present at the February 2 meeting.

Introduced were new members Drs. Robert Maehara, Robert Lindberg, Joseph McNamara, Venudhar Reddy and George Starbuck.

Dr. Robert Millard announced the deaths of two members of the Medical Society, Dr. Wilfred Kurashige who died on January 5, 1971, and Dr. Edward F. Cushnie who died on January 19, 1971.

A special meeting of the HCMS was held Monday, February 22, at 7:30 P.M. in the Mabel Smyth Auditorium to discuss the new RVS.

Dr. John Lowrey made an official appearance as president of the Hawaii Medical Association. In his address to the membership he touched on the highlights of the past year, mentioning briefly the merging of the administrative staffs of the HMA and HCMS which is progressing satisfactorily and efficiently; the problems encountered in the malpractice insurance field; the publication of the new RVS; the involvement of the HMA in the Drug Abuse program, Peer Review, and Dr. O'Rourke's proposal from the School of Public Health. He concluded by thanking the officers and members of the County Society for their help and understanding this past year.

Speaker for the evening was Dr. Harlan Cleveland, President of the University of Hawaii. His talk, "Everybody Wants to Go to College," was informative and thought provoking.

Kauai

Fourteen members were present at the December 1 meeting. Dr. Hoffman's wish to establish a practice in the Haena-Hanalei region was discussed. It was felt that this is not a destitute area. A motion was carried to drop further discussion on the matter at this time.

A letter from Mr. Harold Birnbaum of the American Cancer Sociey was read in regard to sending a person to the San Francisco school that trains operators for tumor registry. The expenses incurred by the person sent are to be maintained by the three Kauai hospitals. This will have to be presented to the hospitals' administrators by the American Cancer Society. It was approved by the membership to give its full endorsement to this project and to notify Mr. Birnbaum accordingly.

Guest speaker, Dr. Ronald Hattis of the Department of Health, discussed their activities regarding continuation of the Rubella program and giving of a booster dose of oral polio vaccine to the school children at this time. He discussed the aspect of meningococcemia and meningococcal meningitis as far as contacts are concerned, and he suggested that if any prophylactic medication be used that it be penicillin rather than sulfadiazine.

Dr. Eugene Rames suggested Evalani Halemanu who works at Coco Palms Hotel as Kauai Heart of the Year. She has had aortic valve replacement and has done remarkably well without any use of anti-coagulants.

Officers elected for 1971 are as follows:

President: Dr. C. Custer
Vice President: Dr. K. Chuang
Secretary-Treasurer: Dr. R. Berry
Delegate: Dr. P. Cockett
Alternate Delegate: Dr. W. McLaughlin
Counselor for Kauai: Dr. P. Kim
Regional Medical Program Advisor: Dr. E. Rames

* * *

1970 SUMMARY OF ACTIVITIES OF THE KAUAI COUNTY MEDICAL SOCIETY

The Kauai County Medical Society held four regular meetings during the year 1970.

On February 2, 1970, a meeting was held with the presence of Dr. John Lowrey, president-elect of HMA; Dr. George Mills, president of the HMA; Dr. Ralph Berry of the Department of Health, and Dr. Uehara and Dr. Morris of the Maui Medical Society who enlightened the members of the Kauai County Medical Society of the relationship of the Department of Health to the various county and state hospitals.

In February of 1970, four students from the high schools on Kauai were sent to Honolulu for the Career Day program. These students in attendance were: M. Kagawa, H. Kosaki, J. Aqui and Rosemarie Tamura.

On February 12, 1970, a Heart and Husband program was presented at the Lihue Parish Hall in cooperation with the Woman's Auxiliary Society to the Medical Society with a good attendance.

On May 11, 1970, the Society held its second regular meeting with Dr. John F. Murray of UC San Francisco, giving a talk on the diagnosis and treatment of acute respiratory failure.

On May 28, 1970, the County Society in cooperation with the various organizations on the island, conducted a disaster drill under the Civil Defense Program with an industrial explosion occurring at the Nawiliwili Harbor.

Toward the end of October, 1970, the Society, cosponsored with the Lions Club a diabetic detection drive for the whole island of Kauai.

Dr. Fred Ansfield, an expert on Cancer Therapy, was on the island of Kauai in the early part of November giving a series of lectures and talks to the physicians on the island.

Evalani Halemanu was presented to the Kauai County Medical Society as being the Kauai Heart of the Year for having a valvular replacement and has done remarkably and is working at the present time.

The Society also continued to endorse the program of the Department of Health in its continuation of the Rubella program for the school children in the early part of December and also endorsed the administration of a booster dose of oral polio vaccine to the school children in the various regions on Kauai.

The last meeting of the Society was held on December 1, 1970, at which time the election of officers was held for the year 1971.

As can be seen from the above activities, the Kauai County Medical Society did have a productive and successful year for 1970.

Maui

Seventeen members attended the January 19 meeting at Heinz Restaurant.

Dr. Morris reported on the proposed Medical Plan which was turned down by the Unions because of the delay. Dr. Uehara also reported on the meeting with the Foundation and Cal-Western. Dr. Morris was requested to chair the committee for medical insurance.

Dr. A. Y. Wong reported on the Diabetes Survey. In 1968, there were 857 tested; in 1969, 1,303 were tested and in 1970, 1,682 were tested. Of the 1,682, 55 were positive Dextrostix and 36 were positive Autoanalyzer. Thirteen reports returned by the physicians showed seven diabetics, two borderlines, two negatives and two known diabetics.

The financial statement for 1969-1970 was approved.

Dues for 1970-1971 were announced as follows:

American Medical Association	$110.00
Hawaii Medical Association	140.00
Hawaii Medical Association Journal	6.00
Maui County Medical Society	59.00
Maui County Medical Society Dinner Assessment	40.00
Total	$355.00

Honorary members will be notified regarding future meetings.

Dr. Romero reported that the Medical Explorers group expanded from nine to 27 members this year. A motion was made by Dr. Burden and seconded by Dr. Morris to send ten students to participate in the Careers Day Program scheduled for February 10 in Honolulu.

Committee appointments will be posted in the Hospital Library. Vacancies are present on different committees and the doctors are requested to sign up. Dr. Percy has been authorized to find a medical secretary for the Utilization Review Committee. A motion was made to raise Mrs. Kitagawa's salary to $200 a year.

Shigella Report: Statistics for the Wailuku Health Center were as follows: 128 rectal swabs done with 28 positive.

Dr. Sowers reported that the Medical Care Survey by Dr. O'Rourke was pending for the coming year. Dr. Morris moved that the Society advise the Councillor to reject the proposal. Motion was seconded and carried by a vote of 8-5.

* * *

The office personnel were guests of the individual physicians for dinner before the meeting at Heinz Restaurant on February 16.

Twenty-one members were present.

Dr. Warshauer and Dr. Nicholson presented a 30-minute explanation of the 1970 RVS Fee Schedule and an explanation of the new RVS with its changes from the RVS of 1965. Important differences were pointed out, such as, the need for a different conversion factor for each section of the RVS book.

Mr. Bob Craft presented the MEO Drug Plan, which is a Senior Citizens Drug Plan for those over 55. By having a card signifying that they are a member of the Plan, they would be entitled to a 10% discount on their drugs purchased at the Craft Drug Stores in Lahaina and Kahului.

The HMA President, Dr. John Lowrey, reported on the consolidation of the staffs of the State Medical Association and the Honolulu County Medical Society which should bring efficiency to the State level and eventually be of assistance to the outer islands. Dr. Lowrey stated that the malpractice insurance status is improving and this was to be reported on more extensively by Mr. Thorson. The HMA is working through the State Legislature to have the statutes of limitations on malpractice be reduced and also to have protection for peer review committees of hospitals so that the records could not be subpoenaed. Dr. Lowrey reported on the O'Rourke Study which he and the Hawaii Medical Association felt to be superficial and that doctors were involved only after the study had been completed. The Council had rejected cooperating with the study in its present form. Dr. Lowrey felt that in the coming years, peer review committees will be extremely important as this is what is being requested on a federal basis.

Mr. Tom Thorson, of the Committee on Professional Liability Insurance, reported that arrangements have been made with the Argonaut Insurance Company for five classes of malpractice and stated the rates. However, it would be necessary for the Hawaii Medical Association, preferably on the County level, to screen all applicants and to review all claims. Mr. Thorson believed that the rates would be stable for 3-5 years and at the end of 20 months, if the claims had been low, dividends or refunds would be available to the participating physicians.

continued page 127



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary

OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288

Our jocose chairman **Varian Sloan** insisted we render a "Happy Birthday" for committee secretary Heather Akana, and the large meeting room reverberated to our discordant harmony. . . . Golf tournament chairman **Toots Fujii** announced that the tournament will be on Friday, April 30, with the field divided into 20-and-lower-handicap doctors playing at WCC, and higher handicappers, non-handicappers, and druggists playing at OCC. When he learned that green fees will be $5.00 and carts an additional $4.00 at both courses, fishing tournament chairman and non-golfer **Andy Morgon** asked, "Why the carts? Can't you walk?" Retorted commissioner and golfer **Cool Wakai,** "You use boats, don't you?" (Meaning, Jesus did it on the Sea of Galilee, but perhaps Andy shouldn't try walking on the Pacific.) [If this is a non-sequitur, make the most of it!—ED.]

The Annual Tennis Tournament is scheduled for Sunday, April 25, at Kam School and Beretania Courts with the first 3 place winners at both courts playing off for the HMA awards. The players can choose their own partners again. . . . The fishing derby will be on on April 18, a Sunday earlier so that those interested can enter all three events, viz golf, tennis and fishing.

The newly organized bow & arrow hunting on Hawaii will have at least two participants (**Bill Davis** *et al*) and Varian suggested "Maybe they can get out there and shoot at each other." The gala entertainment at the Pacific Ballroom banquet will feature master story teller **John Smith** as MC and the Kailua Madrigal Singers competing with Ed Kagihara's musicale. . . .

Locker Room Anecdotes

During an exchange at WCC Clubhouse, we overheard **Ralph Beddow** saying sotto voce to **Paul Tamura,** "Old soldiers never die. . . . They just lose their privates. . . ."

While towelling after a hot shower, WCC member Luigi quizzed us on our knowledge of Japanese: "What is the term for 'hot water'?" "Oyu." "Now, what is the word for 'this morning'?" "Kesa." "And what is 'every morning'?" "Mai asa." "Now put it all together; repeat rapidly." So we unwittingly repeated, "Oyu kesa mai asa," accompanied by the rapturous laughter of this Italian jokester. . . .

Overheard at Mid Pac: "Say, I hear the birth rate is on the decline in the U.S." "Frankly, I find that *inconceivable*." "Well, that's a hard *pill* to swallow."

The Annual Kuakini Interns Christmas Party

Master of ceremonies and hospital assistant administrator Ronald Oba chided **Tsuneichi Shinkawa,** patriarch of all practicing physicians, for being dressed fit for "yakubarai" (Japanese for exorcism, *i.e.,* driving the evil spirits away) in his mod clothes, brilliant red tie, and a matching red beret. . . . Director of medical education **Ed Yamada** presented Dennis Westmoreland from Tennessee with the "outstanding intern" award and a special gift, saying: "This is a gift from the general staff to Dr. Westmoreland and his expectant wife." Dennis' fiancee had just arrived and they were to be married next day. Dennis queried embarrassedly, "Expectant wife? She is not expecting, I hope. . . ." Ed blushed a crimson blush and hurriedly qualified: "His wife-to-be." **Mitsuo Yokoyama,** Research Institute director, introduced his guest and microbiologist–folk singer, Steve Kallestad, who had donated over $3,000 worth of scientific equipment to the Institute. "As you know, we went to Makena Beach [our famous hippie haven on Maui] to study hepatitis. . . . There we met some real women . . . you know, completely nude. . . ." When the mixed audience tittered only, Mitsuo reiterated, "You know what nude means. . . . And we drew blood from their arms. . . ." Mitsuo sighed and seemed to be in Seventh Heaven recalling the ecstasy of those moments. . . . Microbiologist Steve Kallestad, long-haired, youthful president of Kallestad Laboratories, sang several songs he had composed about the simple virtues of life on Makena Beach, dysentery and hepatitis and all. . . . Our great Banzai man, **Tom Maeda,** gave forth with three resounding cheers for the interns, and he was followed by our versatile baritone, **Akira Kutsunai,** who led the audience in Christmas carols. . . .

Notes From the Annual Meeting of the Hawaii Society of Pathologists

The highly successful scientific session and the annual golf tournament were topped only by the gourmet food and drinks at the evening banquet. Past president **Larry McCarthy,** who MC'd the affair, introduced the new president, **Meryl Haber,** who in turn introduced the first guest speaker and Dean of the U of H School of Public Health, **Edward O'Rourke, M.D.** Here are a few rambling notes scribbled between the loud disruptive snores of ENT man **Hideo Oshiro,** who promptly fell asleep when the speaker appeared on the podium: "Hawaii can be an example of universal health care. . . . Money is not the answer. . . . The problem is in facilities and distribution of manpower. . . . In medicine, we are still running a corner grocery store, not a supermarket. . . . Doctors treat people who pay a fee, but they don't necessarily treat those who are ill. . . . What we need is a 'Comprehensive Organized Manpower.' . . . Doctors hide behind three sacred cows: patient acceptance, the patient-doctor relationship, and fee for service."

In rebuff, the next speaker, President of the College of American Pathologists C. A. McWhorter made these remarks: "Dr. O'Rourke's comments are very intriguing, very incisive, and worthy of looking into. . . ." "But," he warned, "when we make changes, let's make changes for the better, *i.e.* for the delivery of better medical care. . . . Changes should not be on the basis of politicians getting votes. . . . Multiphasic health testing offers us an opportunity to investigate new methods of preventive medicine on three levels: The person who is well, but needs reassuring; the person with minor or insignificant problems who needs evaluation; and the person who is really ill. . . ."

President **Meryl Haber** congratulated thoracic surgeon **Ed Izawa** for his 9th hole hole-in-one that afternoon and thanked Ed for the after dinner wine for all 300 plus guests. "This is the first time the American College of Meat Inspectors has been beholden to the American College of Thoracic Surgeons. . . ."

Professional Moves

The Oriental Zodiac proclaims this to be the Year of the "Bore." Before we can welcome the New Year, we have some late 1970 announcements to catch up. **Robert Latta** joined the Straub Clinic in adolescent medicine. Internist **Yoshio Oda,** who was in no great rush to get started, finally settled in the Occidental Building; **Edmund Ing** relocated in the Central Medical Bldg; and GP **Sandra Grummert** opened in the Hawaii Kai Shopping Center. In January, cardiologist **Ijaz Rahman** located at 1741 Nuuanu Ave; dermatologist **Allan Izumi** (**Homer's** son) joined the Straub Clinic, and surgeon **Tadao Nagashima** located at 101 Hualalai St, Hilo, Hawaii. In February, surgeon **Ruben Casile** (who was a surgical consultant in Guam) associated with **Francis Wong** at the Hilo Surgical Clinic; and on Oahu, the Mililani Medical Clinic Inc., opened at Village Center, North Mililani Town.

The Health Department added OBG man **George Murdock** and pediatrician **Philip Hardie, Jr** to the Children's Health Services Division. It also added psy-

chiatrist **Elizabeth Adams** to the Windward Mental Health Center, Kaneohe, and appointed Thomas Burch executive officer for its Research and Statistics Office.

Venerable **David Katsuki**, City and County physician for 13 years, who has a total of 36 years in government service, retired to less controversial pastures, and popular **Joe Hathaway** retired from Hale Mohalu Hospital. Joe was honored by Kalaupapa patients, who gave him a special all-expenses-paid party on Molokai. . . .

Elected, Appointed, and Honored

In our haste to meet the deadline for the last issue, we plumb forgot to congratulate the new officers of the Honolulu County Society. **Tom Frissell**, as president, feels that his main role will be as chairman of the board of governors, which evaluates and makes final decisions on ideas from member physicians. Others elected were **Winfred Lee**, president-elect; **William Dang**, secretary; and **Elmer Johnson**, treasurer. Hawaii County elected **Verne Adams** president, **DeWitt Smith** vice president, **Edward Ballerini** secretary, and **Allan Takase** treasurer. The Hawaii Academy of General Practice elected **Fred Dodge** president, **James Erickson** president-elect, **Michael Hase** secretary and **Fred Reppun** treasurer. On the board of directors are **Takakazu Fukumura, Roscoe Pebley, Harold Lawson**, and **William Walsh**. The Hawaii Society of Pathologists elected **Meryl Haber** president, **Drake Will** president-elect, and **John Hardman** secretary-treasurer. The Hawaii Permanente Medical Group elected **William Dung** chairman of the board of directors. The Children's Hospital appointed Chief of Staff **Henry Yim** as acting medical director to replace

JOHN ROBERT STEPHENSON, M.D.

1927-1970

John R. Stephenson was born in Greenfield, Ohio, November 1, 1927. His schooling through high school was in Columbus. His college education at the University of California at Los Angeles, which began in 1945, was interrupted by two years of service in the United States Navy, in 1946 and 1947. Training as a laboratory technician in the Navy, followed by part-time work in clinical laboratories throughout his undergraduate career, gave him an interest in microbiology destined to last into his years of medical practice. He majored in bacteriology, and pursued microbiology for a year in graduate school, 1950-51. In 1956, he received his degree in medicine from UCLA, and began an internship there in pediatrics.

He and Carolyn Ruth Thompson were married in December, 1955. They came to Honolulu in 1958 for his residency in pediatrics at Kauikeolani Children's Hospital, followed in 1960 by three months' fellowship in pathology at The Queen's Hospital. Their daughters, Mary Christina and Elizabeth Lynn, were born during this time.

In October, 1960, the four Stephensons moved to the mainland. Dr. Stephenson entered private practice in Oceanside, California, in November of 1960. After a year, the family returned to Hawaii to stay. Cheryl Liane was born in 1964, and David Kent in 1965.

Dr. Stephenson was extraordinarily active in the community apart from his busy pediatric practice with Straub Clinic, which began in November, 1961. He was an activist from the beginning in the Honolulu County Medical Society and the Hawaii Medical Association, where he early became a member of the Committee on Maternal and Infant Mortality and the Careers Committee. This led to his heading a Health Careers Day program in subsequent years, which engages the activity of several score doctors and a few hundred high-school students every year.

In 1964 he and Dr. Charles S. Judd, Jr. revived the long defunct medical history society in Honolulu, naming it the Hillebrand Society after Dr. William Hillebrand, a founder of the Hawaii Medical Association and first medical superintendent of The Queen's Hospital, over a century ago.

In 1965 he conceived, organized, and masterminded the first Hawaiian Health Fair. The tremendous success of this led to permanent establishment of the same activity in alternate years.

His school work led to his becoming a medical advisor to Iolani School, and also the Roman Catholic school system, as well as a member of the Oahu Committee for Children and Youth. He also accepted membership on the executive board of the Aloha Council of the Boy Scouts of America, and became chairman of their health and safety committee. In 1968 he established at Straub Clinic a Boy Scout Explorer Post, No. 152, and became its official advisor.

In 1967 he began to limit his practice to the care of adolescents. He was the first physician in Hawaii to do so. In 1968 he became the head of his own department of adolescent medicine, which thrived so that in 1970 he needed, and obtained, an associate ephebiatrist, Dr. Robert I. Latta.

On November 16, 1970, Dr. Stephenson took his own life. It would diminish the stature of this man for anyone to attempt to accurately assign reasons and motivations for this final act.

Honolulu is a better city, its medical society a more effective organization, and Straub Clinic a better medical institution, for having enjoyed the benefits of John Stephenson's participation. He was a most exceptionally gifted man, with more love for his fellow man than most physicians possess. May he rest in peace! He'll be remembered for a long, long time.

Reprinted from Straub Clinic Proceedings, October-December, 1970.

HARRY L. ARNOLD, JR., M.D.

Harry Shirkey, who resigned to devote full time at the UH Medical School as professor of pharmacology and chairman of pediatrics. Harry was also honored by the American Pharmaceutical Association for his "heroic dedication to rational drug therapy for children." He will receive the Hugo H. Schaefer Medal, one of its highest service awards, at the annual meeting in San Francisco. Children's Hospital named **Alan Osher,** former resident who studied at Chicago's Children's Memorial Hospital under **David Allen,** chief of its Pediatric Pulmonary Center. The Big Brothers of Maui, Inc, installed **Mark B. Sowers** as 1971 president. Mayor Fasi appointed **Mario Bautista** to the Board of Parks and Recreation and **John Milnor** to the Oahu Committee on Children and Youth. The Friends of the East-West Center honored **William John Holmes** with a merit award.

Deserving OBG man **George Goto** was honored along with Gov **John Burns** and **James Zukerkorn** at the 5th Annual National Brotherhood dinner at the Ilikai. The citation said "his principal aim as an obstetrician and gynecologist has been to improve the quality of life of women—to give them more civil rights." **Charley Judd** has been named medical adviser for the Hawaiian Sugar Planters Association, succeeding **R. C. Dusendschon,** who now heads the medical department of the Hawaiian Telephone Co.

On a Sunday afternoon in November, untiring ophthalmologist **Perry Sumida** (who goes in for renal dialysis twice a week and still maintains a full schedule) was honored by the Waimanalo Seventh-day Adventist Church and special guests on a This Is Your Life program. The program took a backward glance into Perry's life, how he returned to Hawaii from Japan at age 16, enrolled at the Hawaiian Mission Academy, went on to Pacific Union College for premed, then to Loma Linda for medical school, and on to White Memorial Hospital for residency and to the U of Pennsylvania for grad work.

Paul Gebauer, retired chief of cardiovascular and thoracic surgery at Leahi Hospital, was a very surprised guest of honor at a testimonial in December. Paul entered the banquet room thinking he was attending a party given by some real estate people when instead he found 100 of his former patients and their spouses, who greeted him with "Hail, hail, the gang's all here." A **Reizo Watanabe,** member of the planning committee, said, "We had to do it this way, otherwise he might not have come. He's an unusual man—a haole who doesn't like being in the limelight." [An intriguing ethnic slur—ED.] **Gilbert Ching** described how Paul had done 1,625 major operations since coming to Leahi in 1946 and at least 10 times as many minor operations. As one woman patient put it: "I live every day in gratitude to the doctor. Next to God, it's him. We can't see God, but we *can* see him."

Visiting Professors

As we sat in eager anticipation in Kam Auditorium, **Roger Ogata** very aptly put it: "So we finally got to see the famous **Max Wintrobe!**" So did hematologist **Bob Jim,** in making the traditional end of the lecture series presentation of the famous Queen's Hospital certificate and carnation lei, when he stated with feeling: "We are grateful for his wisdom and philosophy of medicine . . . as well as his basic approach to medicine. . . ." The noted **Max Wintrobe,** we discovered, is a medium-statured, greying dynamo with a patriarchal mien, who sports a bow tie. A beguiling speaker, he speaks in a serious tone, but has a subtle sense of humor and his lectures contain carefully constructed puns. He prefers to dwell on the historical, philosophical, and experimental aspects of hematology, and skims rather rapidly over the nitty gritty material which can be gleaned from his textbook. In fact—whether he intended it or not—we left each lecture feeling that somehow we had to purchase his latest edition, since all the meaty slides were flicked on and off before we could even focus on them in the pitch darkness required for projection. Herein are some gleanings from Max's authoritarian lectures:

re spleen: "The Greeks regarded the spleen as the seat of emotions. . . . Galen, who lived in the Acropolis, called the spleen the organ of mystery, and thought it was associated with melancholy—that it removed melancholia. . . . I suppose this means that lively people have hypersplenism. . . ." (Note the careful buildup toward a typical Wintrobe pun.)

re hypersplenism: "This is a figment of someone's imagination. . . . The primary fault is in the erythvocytes, the leucocytes, or platelets. I don't use the term."

re treatment of leukemias and lymphomas: "One of our responsibilities is to determine what we accomplish by treatment and predict what would happen if we left him alone. I've seen many patients harmed by treatment. . . . The diagnosis of leukemia or lymphoma is a serious condemnation. . . ."

re treatment rationale: "We must think first of all, 'How much can we do in a simple fashion . . . for example, with outpatient care vs long term hospitalization.' . . . Unfortunately, the family's usual reaction is 'Do everything possible.' The objectives of treatment are threefold: to achieve remissions; to avoid injuring the patient; and to preserve his defense mechanisms. . . ."

re new modes of treatment: "We mustn't be too ready to jump at a new treatment which has appeared in a newspaper rather than a medical journal."

re "refractory anemia": This is a wastebasket term for anemias we don't understand. . . ." Then, somewhat whimsically, he added, "But this is what makes life interesting. . . ."

re steroid therapy of ITP: "Doctors give steroids for their own conscience. . . . It is hard to guess in advance which cases will give trouble and which will not. . . . Most cases will resolve spontaneously. . . . It is important for a physician not to make the patient sicker by long term steroid therapy."

re splenectomy for ITP: "I do recommend waiting at least 6 months."

re treatment of ITP and LE: "We should use clinical judgment and not treat laboratory data. . . ."

Quotable Max Wintrobe Quotes:

"We have passed from a therapeutic millennium to pharmacologic embarrassment."

"The desire to take medicine is a feature which distinguishes man from other animals. . . . The more foul tasting and smelling, the more effective. . . . We begin to wonder if man is a rational being. . . ."

"The therapies of earlier years and now differ in that there were very few drugs then and we knew their side effects. . . . Now we have many drugs and their potential for adverse reactions is greater. . . ."

"Physicians have good therapeutic tools—like good swords or good guns—and must know how to use them."

"Adverse reactions are unexpected and unintended effects of drugs. . . . The most important thing is to be alert to their possibility. . . . The key word is *awareness.*"

"Don't use a cannon to kill a mouse. . . . Select the drug with the lowest potentiality for adverse effects. . . ."

"Don't use a shotgun when a rifle will do."

"Use a specific drug for a specific purpose. . . . Avoid combinations. . . ."

"Don't use drugs for prophylaxis or for psychotherapy . . . except in certain well defined situations. . . ."

"Osler says: The unrestrained impulse to treat the patient before making a diagnosis is the chief feature which distinguishes the poor doctor from the good one. . . ."

"Experts may advise . . . salesmen may cajole . . . patients may plead . . . but the physician must decide." . . .

"Anemia is a symptom, not a disease. . . . To find the disease is the challenge to the physician. . . ."

"In steroid and chemotherapy, we have to weigh 'what do we gain and what do we lose?' "

"On the basis of my own experience, it is essential to make an exact diagnosis before treating. . . ."

February brought visiting professor of surgery **Rainey Williams** from Oklahoma U. Rainey, a movie leading man prototype, is a youngish, wavy-haired, stylish dresser with a likeable smile, a sense of humor, and a cowpoke drawl to boot. We caught his lecture on extremity reimplantation, in which he described the successful reimplantation of an arm after a mid humeral amputation in a seven foot basketball player, who regained practically everything, but some thenar musculature and peripheral nerve loss. The patient subsequently went to Ethiopia with the Peace Corps and Rainey says proudly, "I take extreme pleasure in that a Peace Corps medical examination failed to reveal any abnormality of his arm." The seven foot Peace Corps worker subsequently contracted tape worm which it took the medical dept 3 months to eliminate. (No reflection on the Medical Dept, you understand, merely on the length of the fellow). Regarding primary nerve repair, Rainey comments: "It is incredible that we can go to the moon and can't do primary peripheral nerve repair." When **Roy Iritani** asked, "How about lower extremity reimplantation?" he answered with an emphatic "No."

At yet another session, Rainey Williams spoke on Factor VIII and the role of the spleen. His studies with spleen homotronsplantation, using a breed of rare hemophiliac beagles, proved that the spleen stores and releases Factor VIII, but does not itself produce the factor. The use of cryoprecipitates pre and post homotransplantation definitely increased the beagle survivals. Rainey reported that recent work by Starzl and associates seems to point to the liver as being involved in the production of the elusive Factor VIII.

Hors De Combat

The Friendly Sons of St Patrick in Hawaii sent special emissary **John Keenan** to Ireland with a koa bowl for the lord mayor of Dublin, but alas, there is no longer a lord mayor of Dublin. It seems that the lord mayor and his city council were removed from office in 1969 for failing to meet their "legal obligation" and were replaced by an appointed commissioner. Anyway the commissioner was happy to accept the gift so all was not for naught. . . .

As **Les Luke** and his receptionist wife Eleanor were about to close the office for lunch, they were held up and hogtied by a young gunman, only half a block from the main police station. The robber took $11,000 worth of jewelry, including a diamond ring on Les' finger which wouldn't come off, but did when the robber threatened to cut the finger off. . . . Les later said, "If he had done that I would have been hunting him for the next 10 years." "He had the gun at my head. What the hell! You can't argue with a gun."

We note a rash of thefts from MD's again. On Maui, **Jim Fleming** had his medical bag with instruments and drugs stolen from his parked car in Kahului and two weeks later, **Kenneth Haling** had his bag stolen from his car at The Landing restaurant. In Kona, **Wilmot Boone** had $200 cash and a lot of drugs taken from his office. Path Lab and **Winnie Lee** in the Ala Moana Bldg were burglarized. When Winnie reported that "50 to 100 dollars was taken" the reporter jazzed it up as a $5,200 burglary. . . . Poor **Herbert Wong** was hit a 3rd time at 1507 So King St. In the first two burglaries, the enterprising thieves carefully removed the glass louvres from his window. They were forestalled by installing shatterproof glass behind the louvres, so on their 3rd entry, they merely broke the glass on his front door. Undaunted, Herb has now installed heavy wire mesh behind the glass pane. . . .

Cora Manayan has a beef and we don't blame her. The city council voted down her appointment to the police commission after a "trial" which dragged over two months and three votes. As the **Advertiser** editorial put it, "the end result was too much innuendo and suspicion that something deeper was involved," but actually there was none and we somehow get the feeling that it all had to do with the Council's old feud with the mayor. . . .

George Bracher, president of the Hawaii County Medical Society and the Hawaii Chapter of the American Cancer Society, is up in arms. He feels that the high judgments and out-of-court settlements on the mainland are affecting the Big Island's much needed supply of new physicians. One young orthopod who wanted to practice in Hilo was told by the insurance company that they would cover him for the first six months for $5,000, but could give him no assurance as to the next six months. Even practicing doctors are having second thoughts. George says, "Some of the men say that if it gets worse, they'll just quit. . . . Others say that they'll have to pass the increased cost along to their patients. . . ."

Director of Health Dept Laboratories **Henri Minette** has ordered equipment for checking mercury levels in our fresh tuna and swordfish since the FDA report that possibly 25% of canned tuna is contaminated by mercury. With all the daring balloon fish connoisseurs who risk their lives with each bite, we doubt that the threat of mercury poisoning which reputedly causes speech defects, paralysis, blindness, and insanity will deter many local sashimi lovers. . . .

With **Fred Dodge** as spokesman, the Catholic Action Group petitioned the Army to release Spec 5 John LePage from military service. LePage went AWOL here in November while on RR and after being given sanctuary by the Group, he surrendered to military authorities on Christmas Day. Fred stated, "We support his stand against the unjust and immoral war in Southeast Asia

continued page 128

Ulcer Re-lief!

Dicarbosil®
ANTACID

Your ulcer patients and others will respond favorably to it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Radioactive Compounds	Impair platelet function; a marked bleeding tendency may occur with no alteration in prothrombin time.
*Benadryl	
*Thorazine	
*Robitussin or 2-G	
*Salicylates	

A patient receiving oral coumarin anticoagulants and any drug potentiating the coumarin effect will be more responsive to the anticoagulant. Therefore, the required anticoagulant dose will be *lower* than "normal." However, when the drug potentiating the anticoagulant is discontinued, the anticoagulant dose must be increased.

TABLE 2.—*Drugs Reported to Inhibit the Effects of Oral Coumarin Anticoagulants*

DRUGS	MECHANISM OF ACTION
Barbiturates Amytal Seconal Phenobarbital Nembutal Carbrital Chloral Hydrate Placidyl Doriden Griseofulvin Haldol Meprobamate	Increases the rate of metabolism of coumarin anticoagulants by stimulating the hepatic microsomal enzymes responsible for their metabolism. Decreases biologic plasma half life of the coumarins.
Oral Contraceptives	Unclear. Decreases the hypothrombinemic response to the coumarin anticoagulants. Response is similar to that produced by administration of Vitamin K. Stimulate the production of certain procoagulants.
Ascorbic Acid	Unclear. Prothrombin time is shortened
Cardiac Glycosides (Digitalis)	Unclear.

A patient receiving coumarin and drugs inhibiting the effects of coumarin will be less responsive to the anticoagulant. Therefore, he will require a *higher* dose of coumarin to attain the desired anticoagulant effect. It is imperative, that when a patient has discontinued taking a drug inhibiting the coumarin, to reduce the coumarin dose to the desired patient level. There is no set schedule in reducing the dose except empirically based on prothrombin time.

TABLE 3.—*Reported Coumarin Anticoagulant Effect of Other Drugs*

DRUGS	COMMENTS
Tolbutamide	Coumarin anticoagulants potentiate the hypoglycemic effect of Tolbutamide, apparently by inhibiting its conversion to carboxytolbutamide in the liver.
Diabinese	The possibility of severe hypoglycemia should be considered in patients receiving orally any hypoglycemic drug and coumarins.
Adrenalin (Epinephrine)	It is possible, but as yet it has not been demonstrated, that patients receiving anticoagulants might require *lower* than usual doses of catecholamines and related drugs. (e.g. Amphetamine, ephedrine.)

TABLE 4.—*Drugs Reported No Interaction with Anticoagulant Coumarin*

DRUG
Librium
Valium
Diuril
Tetanus Toxoid

SUMMARY

"Whenever a drug is added or deleted from the regimen of a patient receiving warfarin, scrupulous attention must be paid to the prothrombin time, even in the patient whose schedule has hitherto been relatively stable. Furthermore, the physician must be cognizant of drugs that can potentiate bleeding by interfering with platelet function even if there is no alteration in the prothrombin time itself."

Compiled by JAMES MIYASHIRO, B.S., M.S.

REFERENCES

1. Deykin D: Warfarin therapy. *New Eng J Med* 283:801-03 (Oct 8) 1970.
2. Sandler AI: Interaction of oral coumarin anticoagulants. *Handbook of Drug Interaction*, 72-74.
3. Sigell LT, Flessa HC: Drug interactions with anticoagulants. *JAMA* 214:2035-38 (Dec 14) 1970.

ZIMMER MEDICAL INDUSTRIES, LTD.

MILTEX

ORTHOPEDIC EQUIPMENT & SURGICAL INSTRUMENT SPECIALISTS

Don Bloedon
John McCready

Phone 949-0396
949 McCully Street, Room 11
Honolulu, HI 96814

Hawaii Academy of General Practice

continued from 107

by Dr. Sanazaro in 1967 under HMA auspices and by support of the Honolulu Chamber of Commerce and the Watumull Foundation to the extent of $5,000. The Federal government can aid communities to "review" themselves under physician-directed programs by granting funds to medical societies, rather than overburdening physicians with bureaucratic busy-work, mandated by laws.

In the long run, we physicians must come to realize that the only way for us to avoid the burden of increased work occasioned by retrospective peer review—a burden brought on by mounting national social pressures to which legislators are particularly sensitive—is to "chew our cabbage only once." This can be done only via a mechanism of prospective team review, team care of hospitalized illness—"day-to-day, concurrent, before, during, and after." Even by means of a minimum of "team" action—the use of a single consultant in every case—the cost of hospitalized care will rise, but it will not be increased as much as it would be, inevitably, by a Bennett-type amendment!

J. I. Frederick Reppun, M.D.

County Society News *continued from 121*

Mr. Ray Pasche, the local representative of the AMA, reported on national policies. He felt that the cooperation of the physicians in Hawaii was outstanding as compared to the problems in both Nevada and California.

It was reported that ten members and Mr. van't-Grounewout of the Boy Scouts of America went to Honolulu and had an extremely educational experience on the Careers Day excursion.

It was announced that Dr. Iaconetti was nominated as the HMA President-Elect.

Dr. Sowers stated that the Maui Drug Abuse Conference would be held at Maui Community College on March 12 and 13 and were in need of sponsors and financial assistance. It was moved by Dr. Iaconetti and seconded by Dr. Burden that the Maui County Medical Society co-sponsor this Conference and pledge $50 for its support. This was passed unanimously.

The Student AMA-MECO Project was discussed. This project requested that freshmen-sophomore medical students be utilized in county hospitals for an educational program and be paid a $75 a week stipend. After discussion by the County Society, it was felt that the stipend was excessive and that the program was not desirable on a hospital basis. A letter was to be written to the SAMA representative to that effect.

Book Reviews *continued from 109*

A chapter on psychiatry is very well written; and the role of psychiatry is very well summarized in the following words, "Psychiatry for psychiatrists will always be a speciality [*sic*] but psychiatry as an aspect rather than a branch of medicine is something which no good doctor can afford to disregard."

In the section on drugs, there are some things which a lot of physicians may not agree with: for example, the statement that there is no longer any place for desiccated thyroid; and there is no mention of any specific antidotes in the management of poisoning.

In short, though this book is very well written and the material is well presented, its value to an American physician is limited.

B. R. Mehta, M.D.

Also Received

The Frozen Cell: A Ciba Foundation Symposium

Edited by G. E. W. Wolstenholme and Maeve O'Connor, 316 pp., $12.25, J. & A. Churchill, 1970.

This symposium deals with "the physical changes to the biological properties necessary for cell viability" and "the mechanism, or mechanisms, of freezing injury and protection."

Control Processes in Multicellular Organisms. A Ciba Foundation Symposium

Edited by G. E. W. Wolstenholme and Julie Knight, 424 pp., $14.50, J. & A. Churchill, 1970.

An excellent international symposium concerning specific physiological controls concerned in biochemistry, endocrinology, immunology, and neurology.

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

GENERAL PRACTITIONER

Central California General Hospital has two staff openings for immediate occupancy.

Regular salary, based on 40 hour week, can be increased considerably through extra coverage and standby assignments if desired.

Ideal location for outdoor enthusiast, near mountains and lakes, also easy weekend driving to beaches.

Approximately 200 miles to either San Francisco or Los Angeles.

Regular salary over 26M, increase second year.

For further information wire collect

EUGENE BIFULICO, M.D.
CHIEF OF STAFF
1062 South "K" Street
Tulare, California 93277

Dial
537-5353
for
the finest printing service
in the state

star-bulletin printing company
420 WARD AVENUE HONOLULU, HAWAII 96814

Notes & News *continued from 125*

and ultimately against all war as a method of trying to solve man's problems." Poor Fred! Back in November, he and his son were jailed for trespassing on the Chimanate school grounds while giving sanctuary to the same AWOL soldier. Staunched an ddevoted friend Sster Maureen, SFH administrator, had to leave a Beverly Paine review meeting to march down to the cell block to bail Fred out and to console his grieving wife, sparrow. . . .

Neurosurgeon **Maurice Silver** and 16 of his patients have filed a $17.8 million suit against local hospitals, doctors, and others charging that the defendants have conspired against him since 1961 to prevent him from practicing because he was a Jew! In early January, Silver had Federal Judge Martin Pence disqualified on grounds that Pence once told a doctor that Silver "is the most dishonest doctor I've ever seen in court." He also moved to disqualify Federal Judge Nils Tavares because Tavares allegedly showed personal prejudice against him in a civil case. Tavares later voluntarily withdrew as trial judge with this statement: "The vehement, emotional, exaggerated and intemperate pleadings, motions and statements of some of the parties and their counsel are such that this judge feels that in this case they may appear to have cast a shadow on his judicial stature and reputation. . . ."

State Board of Education Chairman **Dick Ando** reacted to an assistant superintendent's statement to the board that the DOE staff members were tied up trying to answer questions and resuests from the House Committee on Education. Dick had said, "I think we have too long let our people—the superintendent and staff—jump at any sound a legislator makes or any legislative resolution. Speaker of the House Tadao Beppu sent Dick an explanatory letter assuring him that the requests for information were not made "merely for the purpose of making the superintendent or the staff jump or to interfere directly with the department's activities," and concluded that "it will be to our better interest and that of the State if a spirit of cooperation is fostered instead of one of divisiveness."

Announcements

PHYSICIAN AVAILABLE for locum tenens work four to six weeks in July or August. Age 36, licensed, certified in pediatrics. Please write: Edward B. Brown, M.D., 1 Brookmead Dr., Cherry Hill, New Jersey 08034.

POSTGRADUATE COURSE: CLINICAL PHARMACOLOGY, WITH EMPHASIS ON NEWER DRUGS

Presented by the American College of Physicians, April 19-21, 1971. Location: University of Michigan Medical Center, Townsley Center for Continuing Medical Education, Ann Arbor, Michigan. For information and application write: Registrar, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

CANADIAN SYMPOSIUM ON MICROBIOLOGY PROJECT

A symposium on the Microbiology Project of the Canadian Medical Expedition to Easter Island will be held in Montreal on April 26, 27, and 28, 1971. For information write: Dr. G. L. Nogardy, Departement de Microbiologie et d'Immunologie, Universite de Montreal, C.P. 6128, Montreal 101, P.Q. Canada.

CONFERENCE ON MALPRACTICE

The American College of Legal Medicine will hold an important Conference on Malpractice at the Royal Orleans Hotel, New Orleans, Louisiana, May 7-8, 1971. For further information contact: Cyril H. Wecht, M.D., J.D., F.C.L.M., President, American College of Legal Medicine headquarters, 1340 N. Astor Street, Suite 1201, Chicago, Illinois 60610.

ATTENTION—PHYSICIANS AND ALLIED SCIENTISTS

The Second National Conference on Breast Cancer will be held at the Century Plaza Hotel in Los Angeles, California, on May 17 to 19, 1971. The Conference will present a multidisciplinary review of the breast cancer problem in the United States including epidemiology, etiology, detection, diagnosis and management.

Address correspondence to: Esther Kelly, Professional Education, American Cancer Society, Inc., 219 East 42nd St., New York, N.Y. 10017.

POSTGRADUATE COURSE: IMMUNOLOGIC CONCEPTS OF HYPERSENSITIVITY IN MAN

Presented by the American College of Physicians, May 19-22, 1971, at the Statler Hilton, Buffalo, New York, assisted by Continuing Medical Education School of Medicine, State University of New York at Buffalo. For information and application write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

POSTGRADUATE COURSE: CLINICAL ENDOCRINOLOGY: PHYSIOLOGICAL BASIS FOR CURRENT DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Presented by the American College of Physicians May 24-28, 1971, at the Townsley Center for Continuing Medical Education, University of Michigan Medical Center, Ann Arbor, Michigan. For information and application write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104.

POSTGRADUATE COURSE: SELECTED TOPICS ON THE PATHOPHYSIOLOGY OF CLINICAL GASTROENTEROLOGY

Presented by the American College of Physicians June 1-4, 1971, at the University of California San Francisco Medical Center, Medical Sciences Auditorium, 3rd and Parnassus Avenues, San Francisco, California. For information and application write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

EDUCATIONAL COURSE

A continuation course on "Clinical Electroencephalography" will be held September 13-15, 1971, in Minneapolis, Minnesota. The course is designed to review the principal applications of the EEG to clinical medical practice, and is sponsored by the American Electroencephalographic Society.

Inquiries about further details of the course or registration procedure should be addressed to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901.

In Memoriam *continued from 112*

ber of the Alameda Board of Education.

Dr. Tisdale died in Alameda on July 14, 1925, at the age of 67. He was a past exalted ruler of the Oakland Lodge of Elks.

Trent

Medical Personnel Bureau

LINDA LOUISE TRENT—Director

"QUALITY WITH INTEGRITY, EFFICIENCY, COURTESY"

We offer complete coverage for all employment in:

- HOSPITALS
- CLINICS
- EXENDED CARE FACILITIES
- CONVALESCENT HOMES
- MEDICAL and DENTAL ASSISTANTS
- OFFICE PERSONNEL
- LABORATORY and X-RAY TECHNICIANS
- RESTORATIVE DEP'T.—O.T.'s and P.T.'s.
- NURSES AIDS
- COMPANIONS
- PHARMACEUTICAL PERSONNEL

All Personnel carefully screened and evaluated

24-HOUR SERVICE

Female and Male
Hawaii Licensed Private Duty
Registered and Practical Nurses.

Trent

Medical Personnel Bureau

24-HOUR SERVICE

1311 Kapiolani Blvd., Room 407

Honolulu, Hawaii 96814

Telephone: 521-2948

DAILY HOURS:

Monday through Friday—8 a.m. to 4 p.m.

"The specializer."

Thiosulfil® Forte
(sulfamethizole 0.5 Gm.)

It hits uropathogens where they live... hard and fast!

Thiosulfil Forte, a highly specialized sulfonamide, delivers its potent and rapi antibacterial action *locally*. In the urinary tract. This is where the activity i needed when you're treating cystitis or prostatitis. Thiosulfil Forte is a *tru specific*—hits susceptible uropathogens where they live...hard and fast.

Rapidly absorbed and rapidly excreted, there is so little concentration in th respiratory tract and other tissues that the *only* indication for Thiosulfil Fort is in urinary tract infections. Most of the drug (more than 75 per cent in 8 hours reaches the urinary tract in a free and active form...to fight the infection.

BRIEF SUMMARY—Bacteriostatic agent for use in **Urinary Tract Infection (due to susceptible organisms)—INDICATIONS:** Thiosulfil is indicated in the tre ment of urinary tract infections—cystitis, urethritis, prostatitis, pyelonephritis, and pyelitis—caused by susceptible bacteria, normally **Escherichia co Klebsiella aerobacter, Staphylococcus aureus, Proteus mirabilis,** and less frequently, **Proteus vulgaris.** Thiosulfil is useful in the management of patien prone to urinary tract infection because of conditions such as pregnancy, diabetes, or pathology not correctable by surgery. As with most antibiotics ar all antimicrobials, Thiosulfil is most effective in acute, uncomplicated urinary tract infections. **CONTRAINDICATION:** Thiosulfil is contraindicated in patien hypersensitive to sulfonamides. **WARNINGS:** Sulfonamides should not be used to treat group A streptococci infections or their sequelae. The occurrenc of sore throat, fever, pallor, purpura, or jaundice during sulfonamide administration may be an early indication of serious blood dyscrasias. Frequent bloo counts and renal function tests should be carried out during sulfonamide treatment, especially during prolonged administration. Microscopic urinalyse should be done once a week when a patient is treated for longer than two weeks. Urine cultures should be made to confirm eradication of bacteriuri Clinical symptoms in acute, uncomplicated urinary tract infections frequently disappear spontaneously after three days, and their disappearance cannot b taken as evidence of absence of bacteriuria. (Para-aminobenzoic acid must be added to the culture media while the patient is on sulfonamide.) Becaus sulfonamides are bacteriostatic, development of resistance by the involved organisms is frequent. **PRECAUTIONS:** Sulfonamides should be administere with caution to patients with severe allergy or bronchial asthma. Sulfonamides should be given with caution to patients with severe impairment of hepati or renal function. They should be administered with caution to glucose-6-phosphate dehydrogenase-deficient patients since sulfonamides may cause hem

**Thiosulfil® Forte—
It works
where you want it...**

That's also why you don't need excessive loading or
riming doses. And the patient on Thiosulfil Forte uses
ess sulfonamide...gets more action for his money.

Specific For Urinary Tract Infections

Thiosulfil® Forte

Brand of

sulfamethizole 0.5 Gm.



sis in such patients. Adequate fluid intake must be maintained in order to prevent crystalluria. Sulfonamides ear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides), and oral ypoglycemic agents. Cross-sensitivity may exist with such agents. **ADVERSE REACTIONS:** Like all sulfonamides, hiosulfil (sulfamethizole) could cause any of the various allergic reactions (minor to severe) in patients with nsuspected sulfonamide hypersensitivity. There have been isolated reports of serum sickness, periarteritis odosum, pancreatitis with hepatitis, meningitis, aplastic anemia, thrombocytopenia, drug fever, methemo-lobinemia, and cyanosis. Skin rashes, urticaria, and pruritus may occur with its usage. Headache, dizziness, ausea, and, rarely, vomiting have been reported. **HOW SUPPLIED:** No. 786—Each tablet contains sulfamethi-ole 0.5 Gm. (scored), in bottles of 100 and 1,000.

AYERST LABORATORIES, New York, N.Y. 10017

Ayerst®

7030

Hawaii Medical Ass'n *continued from 116*

there are also brand name companies and generic name companies that probably cannot be relied upon to produce drugs with consistent quality. It recognizes that large brand name companies are among the largest producers of generic products, and that a generic house may spend a considerable portion of its efforts producing and labeling branded items for large brand name houses.

The Association encourages any means by which patients may be ensured of consistently high quality drugs at low cost. It supports the efforts of the hospitals, government organizations and medical groups in their efforts to accomplish this end through pharmacy and therapeutic committees and formularies. It would admonish these organizations to evaluate their drug suppliers as carefully as is reasonably possible. It does not believe that the use of brand names or generic names is important in this context; the name of the drug being secondary to the reputation of the supplier, and his ability to meet competitive prices.

The Association would discourage any program that would not ensure the patient being supplied with drugs produced by quality manufacturers. There is not sufficient governmental control of drug quality at this time (Winter 1970) to ensure that outpatients will consistently receive good drugs when prescribed by generic name."

ACTION:

It was voted to approve the position statement as amended.

(2) That Council accept the recommendation from the Bureau of Research and Planning as a result of their February 11 meeting regarding the Bennett Amendment.

ACTION:

It was voted to accept Recommendation No. 2.

(3) That Council endorse the Report of the Hawaii Committee on Drug Abuse, commend the Hawaii Committee on Drug Abuse for their comprehensive study, and address letters to the Governor, President of the Senate, Speaker of the House, etc. indicating the endorsement of the HMA.

ACTION:

It was voted to approve Recommendation No. 3.

Commission on Public Health: The report was circulated, reviewed, and discussed. The following recommendations were made:

(1) That Council approve the Chronic Illness and Aging Committee work with DSS on developing improved movement of patients from acute hospitals to Extended Care Facilities (skilled nursing care home, intermediate care home, and boarding homes).

It was pointed out that the cost of patient care in these facilities reflects a large amount in the DSS budget. Mr. Millar of the DSS informed the committee that this is a real problem which creates a backlog of transfers from the acute to intermediate nursing home. It was also pointed out that the Legislature is not aware of this problem and that it should be brought to their attention.

A recommendation was made that if a physician stipulates in the patient's chart that the patient is not in need of acute hospital care then that hospital cannot collect the amount of money due them for that particular type of care, therefore, it decreases the amount of money available to that patient, the facility will have to accept a lesser amount and the facility is forced to move the patient out.

ACTION:

It was voted to allow the Chairman of the Commission on Public Health to develop a statement and send it to the DSS with copies to the President of the Senate, to the Speaker of the House, and to the Chairman of the Com. on Human Resources.

(2) That Council approve the recommendation of the Communicable Disease and Immunization Committee to further investigate with the Superintendent of the Department of Education in assigning an educator to develop a total program in venereal disease.

ACTION:

It was voted to allow the Chairman of the Commission on Public Health to write a letter to the Superintendent of DoE relative to Recommendation No. 2.

(3) That Council approve the recommendations of the Diabetes Committee (a) that the Beckman Glucose Analyzer be used for diabetes screening, (b) that the Lions Club request to support screening programs for diabetes under the guidance of professional people be accepted, and (c) that a Diabetes Seminar sponsored by the HMA and utilizing outside funds be endorsed.

ACTION:

It was voted to approve the recommendations of the Diabetes Committee.

(4) That Council approve the recommendations of the School Health Committee (a) that school physical examinations for Punahou, Iolani & DoE be established on the birthday month, (b) that support of the School Health Services complex be continued, and (c) that the DoE's SHES program on Health Education be endorsed.

ACTION:

It was voted to approve the recommendations of the School Health Committee.

(5) That Council approve the recommendations of the Environmental Health Committee: (1) that the Environmental Health Committee be allowed to confer with the members of the University of Hawaii "Community Studies on Pesticides"; (2) that a letter be directed to the Director of the Department of Health and the Department of Transportation re the sewage pollution problem and the inadequacy of sanitary facilities at the Ala Wai Boat Harbor (a. installation of adequate portable sanitary facilities at Ala Wai Yacht Harbor as an emergency measure, b. enforcement of existing public health regulations after such installation is complete, c. construction of adequate toilet, washroom and shower facilities, d. report from the Department of Transportation re the description of the sanitary facilities planned for present and future boat harbors); (3) that all recreational waters of the State of Hawaii which are subject to any significant threat of pollution be tested and that monitoring be made public without delay; (4) that the HMA ask the legislature for the provision of adequate funds and power for the Department of Health to enable them to study, police, and enforce measures directed toward a safe healthy environment; (5) that the Air Quality Standards of the Hawaii Tuberculosis and Respiratory Disease Association be adopted; (6) that a baseline study of environmental lead, arsenic, and mercey, including sampling of ocean and stream bottom life and sediments, as well as levels in local algae, plankton, reef fishes and human autopsy specimens be done; (7) that efforts be made to design out of existence the sources of solid wastes; and (8) that the following recommendations concerning population control be endorsed (a. government subsidy and expansion of existing Family Planning Clinics, b. aid to private organizations such as Zero Population Growth and Planned Parenthood, c. encouragement of "full coverage" by insurance carriers for all persons, regardless of marital status, for procedures

continued page 134

MAY WE HELP YOU

TO HELP YOUR PATIENTS?

Complete Line – Orthopedic Supports
Artificial Limbs – Invalid Equipment

Certified Fitters

C. R. NEWTON CO. LTD.

1575 S. BERETANIA STREET
HONOLULU, HAWAII 96814
TELEPHONE 949-8389 OR 949-6757

OXYGEN AIR-CONDITIONED

24-HOUR SERVICE

Physician's



531-0477

AMBULANCE SERVICE, INC.

Hawaii's Finest

MEDICAL PLACEMENT BUREAU
and
NURSES' REGISTRY

24 HOUR SERVICE

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

1415 Kalakaua Avenue **Suite 210**
Phone 949-1237

Call Us for
OPHTHALMIC INSTRUMENTS

OPTICAL DISPENSERS
of Hawaii, Inc.

532 PROFESSIONAL CENTER BLDG.
1481 SO. KING STREET — 955-6314

1133 BISHOP STREET
HONOLULU, HAWAII — 537-6570

1441 KAPIOLANI BLVD., SUITE 312
HONOLULU, HAWAII — 949-4795

103 PROFESSIONAL CENTER BLDG.
30 AULIKE STREET
KAILUA, HAWAII — 261-6030

Complete Contact Lens Service Available

Equipment Distributors for:

BAUSCH & LOMB, AMERICAN OPTICAL CO., SHURON, TITMUS, RELIANCE, WELCH ALLYN, KEELER AND LAWTON INSTRUMENTS.

CARL ZEISS, INC.

to terminate pregnancy, d. idealization of the small family in the media, advertising, and political philosophy of the government (encouragement of large families should be treated as irresponsible behavior).

ACTION:

It was voted to refer all recommendations except for Recommendation No. 2 back to the committee for further clarification and which may be submitted to the House of Delegates.

It was voted that Recommendation No. 2 be approved.

Commission on Interprofessional and Public Relations: The report was circulated, reviewed and discussed.

ACTION:

It was voted to accept the report as circulated.

Bureau of Planning and Research: At a special meeting of the Council on January 25, the Bureau was asked to consider the Bennett Amendment in relation to PSRO. The subject was discussed at the February 11 meeting of the Bureau at which time Dr. James Z. Appel and Dr. Dale Schumacher were present. The Council was advised that the Bureau finds a significant need to establish some type of peer review system that may or may not be tied with continuing education plans and that this be done promptly and fairly so that a favorable type of review system, in cooperation with others in the community but under the direction of HMA, can be obtained.

The Council was asked to approve sending a letter to Mr. Bennett giving the HMA's attitude on PSRO. It was felt that Mr. Bennett should be made aware that the HMA feels that all peer review committees be under the auspices of the medical association, that a pilot program should not be underwritten at the physicians' expense, that it is against the idea of physicians being involved in any way in matters other than its own professional problems, and that it does not feel that peer review will solve the cost of Medicare and Medicaid.

ACTION:

It was voted to write a letter to Mr. Bennett with a copy to Senator Fong relative to the HMA's attitude regarding PSRO.

Finance Committee: The report was circulated, reviewed, and discussed. The committee made the following recommendation: (1) That a procedural audit be accepted for July, 1971, and that a certified audit be requested for January, 1972.

ACTION:

It was voted to approve the recommendation of the Finance Committee.

Nominating Committee: The Chairman of the Committee submitted the following slate for Council approval:

President Elect.....William E. Iaconetti
Treasurer.....Thomas P. Frissell
AMA Delegate.....George H. Mills
AMA Alt. Delegate.....Theodore T. Tomita
Councillor from Kauai.....Peter Kim
Councillor from Oahu.....William W. L. Dang

UNFINISHED BUSINESS

Progress Report on the Proposed Hawaii Research and Development Program for Improved Health Services sponsored by the UofH School of Public Health:

Dr. Lowrey reported that he met with members of Comprehensive Health Planning and everyone present at

that meeting were in favor of cooperating with the proposal sponsored by the UofH School of Public Health. Dr. Lowrey asked Council to consider the following statement:

"The Hawaii Medical Association has initiated, partially funded and cooperated with many medical care studies in Hawaii. We are happy to cooperate with the School of Public Health's 'Proposed Hawaii Research and Development Program for Improved Health Services' provided (1) our members' involvement is made known to us before the fact, and (2) data submitted to the National Center for Health Services Research and Development is simultaneously submitted to the Governor's Task Force on Health Systems as constituted in Dr. O'Rourke's Technical Proposal for evaluation and comment."

There was considerable discussion about the statement.

A substitute motion was made as follows:

ACTION:

It was moved and seconded to adopt the following statement: "The Hawaii Medical Association has initiated, partially funded and cooperated with many medical care studies in Hawaii, and has consistently supported the improvement of health care. However, in view of the HMA's experience to date with the School of Public Health's proposed Hawaii Research and Development Program for Improved Health Services, the Hawaii Medical Association cannot support the proposal.

The motion was passed.

Progress Report on Malpractice Insurance: The Malpractice Insurance Committee requested Council to approve its recommendation that HMA proceed immediately with final negotiations for the Plan proposed by the Argonaut Insurance Company.

ACTION:

It was voted to approve the Committee's recommendation that HMA proceed immediately with final negotiations for the Plan proposed by the Argonaut Insurance Company.

Status of the HMA Study on the Quality of Personal Medical Care: Dr. Lowrey reported that the hospital seminars are, at the present time, being conducted by Dr. Beverly C. Payne and staff at the Makaha Inn. Dr. Payne has given the HMA a progress report of the seminars deleting the names of hospitals involved. The Council was informed that the hospital seminars are confidential and information is pertinent to only those hospitals involved and this is the reason that names of individual hospitals were omitted from the report. Council was also informed that if anyone would like to peruse the report, it is available in the HMA office.

NEW BUSINESS

Report of Woman's Auxiliary: Mrs. Lawson reported the Woman's Auxiliary activities.

AMA Management Consultants: Council was informed that the AMA has management consultants who are available, at AMA's expense, to come to Hawaii to study the present HMA-HCMS committee structure.

ACTION:

It was voted that HMA request of the AMA to send its management consultants to Hawaii to study the HMA and HCMS committee structure.

ADJOURNMENT

The meeting adjourned at 9:15 P.M.

R. VARIAN SLOAN, M.D.
Secretary

HONOLULU, HAWAII

44 Physician multispecialty group in downtown Honolulu wishes additional Board eligible or Board certified physicians in Dermatology and the following subspecialists of Internal Medicine: Nephrology, Allergy, Hematology, Endocrinology, and Pulmonary Disease.

Excellent opportunities for growth.

New facility to be completed in 1972. Partnership after one year. Excellent fringe benefits.

Teaching opportunities available.

Clinic located immediately adjacent to 400 bed general hospital.

it's the real thing



COCA–COLA BOTTLING COMPANY
OF HONOLULU, INC.

Our "Angels"

PAGE

Arch Laboratories
Dicarbosil 125

Ayerst Laboratories
Thiosulfil Forte 130, 131

Becton, Dickinson & Co.
BDP—103 Plastipak Insert (between 76 & 77)

Bishop Trust Co., Ltd. 78

Brainard & Black, Ltd. 136

Burroughs Wellcome & Co. (U.S.A.) Inc.
Empirin 80

Campbell Soup Company
Asparagus 99

Coca-Cola Bottling Company
of Honolulu, Inc. 135

Hawaii Medical Service Association 86

Honolulu Medical Group, The 135

Lederle Laboratories
Achrostatin 85

Lily, Eli, & Co.
Ilosone Liquid 250 88

Mead Johnson Laboratories
Prosobee 81

Medical Placement Bureau 134

National Drug Company
Orenzyme/AVC Insert (between 84 & 85)

PAGE

Newton, C. R., Co., Ltd. 133

O'Leary, Lydia, of Hawaii 121

Optical Dispensers of Hawaii, Inc. 134

Physician's Ambulance Service, Inc. 133

Robins, A. H., Co., Inc.
Allbee with C/Donnatal Insert (between 80 & 81)

Roche Laboratories
Efudex 82, 83
Larobec 137
Librax 74, 75
Valium 140

Searle, G. D., & Co.
Dem/ulen 138, 139

Smith Kline & French Laboratories
Thorazine 87

Star-Bulletin Printing Company 128

Stuart Pharmaceuticals
Mylanta 76

Trent Medical Personnel Bureau 129

Williams Mortuary 127

Winthrop Laboratories
Neo-Synephrine 117
Phisohex 84

Zimmer Medical Industries, Ltd. 126

INSURANCE EXCLUSIVELY

Brainard & Black, Ltd.

1712 S. King Street, Honolulu 96814

Telephone: 949-0031

"Small enough to know you,
Large enough to serve you"



Multivitamins with pyridoxine can impair levodopa therapy

Your patient with Parkinson's disease and syndrome may be taking a nonprescription multivitamin containing B_6.
Vitamin B_6 reportedly reduces the benefits of levodopa, and may lead to discontinuance of therapy because of apparent ineffectiveness.

Larobec provides needed nutritional support without pyridoxine (vitamin B_6)...and helps ensure that your levodopa therapy is not impaired by self-medication with a pyridoxine-containing multivitamin preparation.

Complete Prescribing Information:
Each Larobec tablet contains:

Thiamine mononitrate (vitamin B_1)	15 mg
Riboflavin (vitamin B_2)	15 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin (vitamin B_{12})	5 mcg
Folic acid	0.5 mg
Ascorbic acid (vitamin C)	500 mg

Description: For prophylactic or therapeutic nutritional supplementation concomitant with levodopa therapy in patients with Parkinson's disease and syndrome, Larobec provides high potency dosages of the major B-complex vitamins, without pyridoxine (vitamin B_6) which has been reported[1,2] to reduce the clinical benefits of levodopa therapy. B-complex vitamins are essential in the anabolism of carbohydrate and protein and in hematopoiesis. Larobec also contains therapeutic quantities of ascorbic acid, a substance involved in intracellular reactions such as tissue repair and collagen formation.
Indications: Larobec is indicated for supportive nutritional supplementation when a water-soluble vitamin formula (without pyridoxine) is required prophylactically or therapeutically in patients under treatment with levodopa.
Warning: Administration of vitamin B_6 may be required if signs of pyridoxine deficiency develop. Larobec is not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.
Dosage and Administration: One or two tablets daily, as indicated by clinical need.
How Supplied: Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.
References:
1. Duvoisin, R. C., *et al.*: *Trans. Amer. Neurol. Assoc., 94*:81, 1969. 2. Cotzias, G. C.: *J.A.M.A., 210*:1255, 1969.

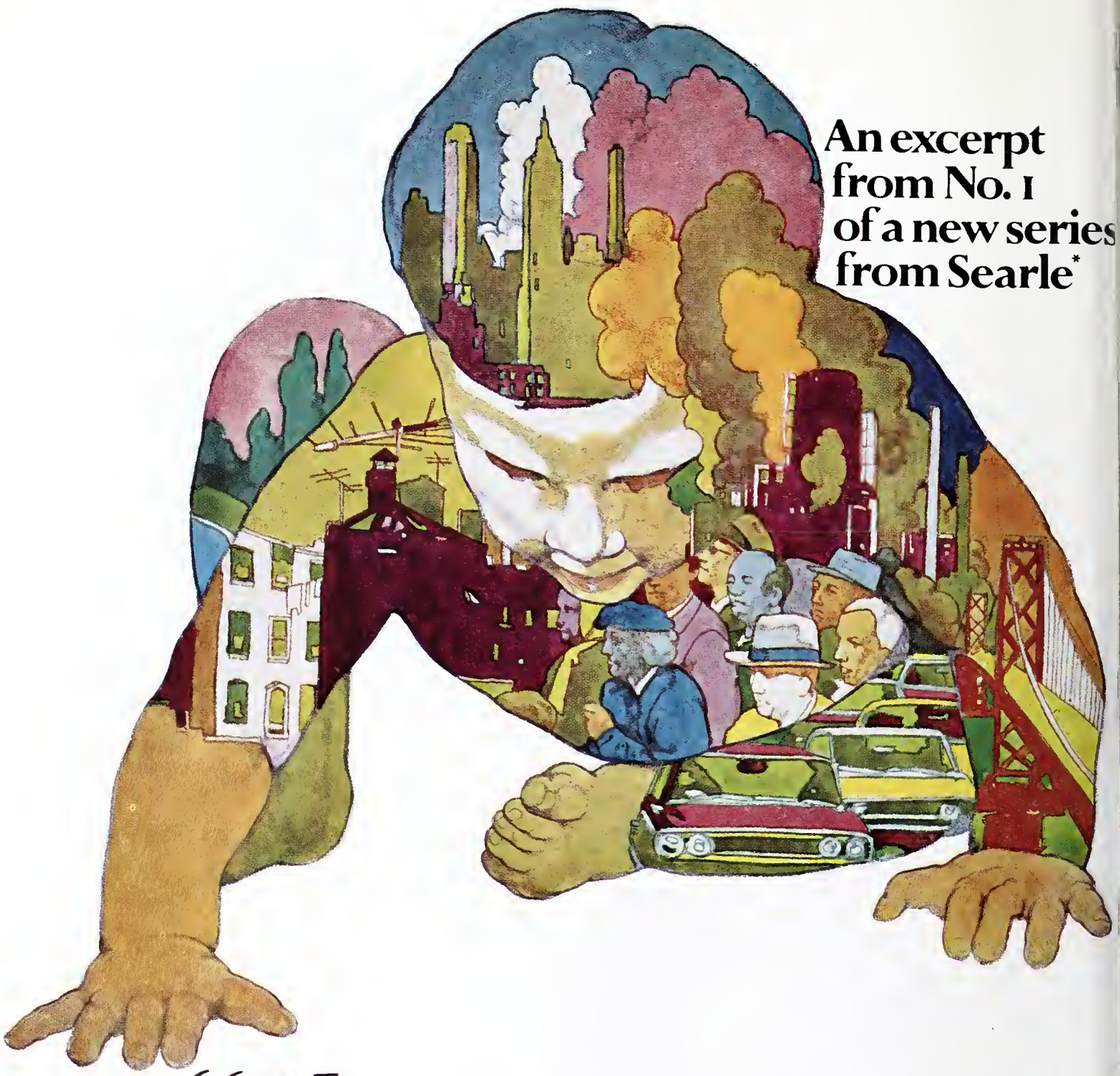


The "incomplete" B-complex

Larobec™
TABLETS

High-potency nutritional support under prescription control

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



An excerpt from No. 1 of a new series from Searle*

"The Ecology of Birth Control"

75 million more Americans—what impact on health care?

Because of a declining birthrate in the United States—attributable in no small measure to the widespread use of contraceptives—our population in thirty years is expected to be *only* 280 million, while the world population is expected to double, reaching 7 billion.

But the word "only" has an ironic ring to ecologists who warn of cities resembling overcrowded, contaminated rat colonies, of respiratory and mental diseases reaching epidemic proportions and of a health-care community virtually overwhelmed by the burden.

The global consequences may be no less devastating. Ecologists estimate that every American has roughly fifty times the negative impact on the Earth's life-support systems of, say, a citizen of India. In these terms, adding 75 million Americans would be equivalent to adding 3.7 billion Indians to the world population.

**For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.* Explored in the forthcoming issues will be the role of birth control on family pressures and its effects on the family; the influences of poverty, ethnic factors and marital status; its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

SAN FRANCISCO
CENTER LIBRARY

MAY / JUNE 1971

HAWAII MEDICAL JOURNAL

VOLUME 30 / NUMBER 3



Efudex®
(fluorouracil)
cream/solution

In the treatment of solar/actinic keratoses–
An alternative to cold, fire and steel

2/23/68
Before treatment with 5% 5-FU cream. Patient R. G., 78 years old, shows extensive skin changes due to weathering and severe solar/actinic keratoses.

3/26/68
Following one month of therapy. Intense erythematous reaction is seen at sites of keratoses. Normal skin has not reacted. Some areas which had reacted initially have undergone healing despite continued topical application of 5% 5-FU.

6/11/68
Ten weeks after discontinuance of therapy. All areas have healed completely. Residual mild erythema remains in some areas. This patient also had seborrheic keratoses which, as expected, have not reacted. There is no evidence of residual lesions or recurrences.



ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

An alternative to conventional therapy

Efudex (fluorouracil) offers the physician a topical alternative to cryosurgery, electrodesiccation and cold-knife surgery in the treatment of solar/actinic keratoses. It is effective, comparatively inexpensive and specially well suited for treatment of these multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When new lesions appeared, repeated courses of Efudex therapy proved effective.*

Predictable therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two or three months before gradually receding. Since this response is so predictable, lesions which do not respond should be biopsied.

Two strengths—two dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two important considerations: First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann - La Roche Inc., Nutley, New Jersey.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



new
Efudex®
(fluorouracil)
cream/solution

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

HAWAII MEDICAL JOURNAL

VOLUME 30, NUMBER 3

MAY-JUNE, 1971

$6.00 A YEAR • $1.00 A COPY

Advertising Representative
LILITH JURRY
Phone 946-0053

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1971, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

Published Bi-Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, MARILYN O. WALL
Associate Editor, MERYL H. HABER, M.D.
Contributing Editor, ROBERT H. MOSER, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.

The Hawaii Medical Association

Officers 1971

President	JOHN J. LOWREY, *Honolulu*
President-Elect	HERBERT Y. H. CHINN, *Honolulu*
Past President	GEORGE H. MILLS, *Honolulu*
Secretary	R. VARIAN SLOAN, *Honolulu*
Treasurer	THOMAS P. FRISSELL, *Honolulu*
County Presidents	
Hawaii County	VERNE ADAMS, *Pahala*
Honolulu County	THOMAS R. FRISSELL, *Honolulu*
Kauai County	CHARLES CUSTER, *Waimea*
Maui County	J. MARK B. SOWERS, *Wailuku*
Delegate to AMA	GEORGE H. MILLS, *Honolulu*
Alt. Delegate to AMA	THEODORE T. TOMITA, *Honolulu*

Councillors 1971

Maui	WILLIAM E. IACONETTI
Honolulu	GROVER H. BATTEN
Honolulu	WILLIAM W. L. DANG
Honolulu	RICHARD D. MOORE
Hawaii	ED B. HELMS
Kauai	YONEMICHI MIYASHIRO

Officers—County Societies—1971

HAWAII		HONOLULU
VERNE ADAMS	President	THOMAS FRISSELL
DEWITT H. SMITH	Vice President	WINFRED LEE
EDWARD BALLERINI	Secretary	WILLIAM DANG
ALLAN TAKASE	Treasurer	ELMER JOHNSON
MAUI		**KAUAI**
J. MARK B. SOWERS	President	CHARLES CUSTER
DENIS FU	Vice President	KATOK CHUANG
JOHN WITHERS	Secretary/Treasurer	ROBERT BERRY

IT'S THEIR FUTURE...

But it's up to you to plan it. Your children gaze into the mystery of the future. But their lives in twenty or thirty years depend substantially on your vision today. They depend on your abilities with investments, taxes, estates, and trusts. And that's our field. We'd like to help . . .



BISHOP TRUST CO., LTD.

Bishop and King • Phone 536-3771
Honolulu, Hawaii 96813

HAWAII MEDICAL JOURNAL

Contents

Volume 30, No. 3 • May-June, 1971

Articles

Hiatus Hernia and Gastroesophageal Reflux 163
J. Judson McNamara, M.D.

The Art and Gentle Science of Pisse-Prophecy 166
Kenneth D. Gardner, Jr., M.D.

Rheumatoid Factor and Antinuclear Antibody in Systemic Lupus Erythematosus, Rheumatoid Arthritis and Infectious Mononucleosis 170
Carl K. Ichida, and Mitsuo Yokoyama, M.D.

Three Months' Experience with Thiothixene 174
Juan Carlos De Tata, M.D.

Thiothixene in Chronic Schizophrenia A Clinical Trial 178
A. Hamdi Yilmaz, M.D.

Hawaii Life Tables Values by Causes of Death: 1959-61 184
Chai Bin Park, M.D., and Y. Scott Matsumoto, Ph.D.

Editorials

In Memoriam—Doctors of Hawaii 192

Features

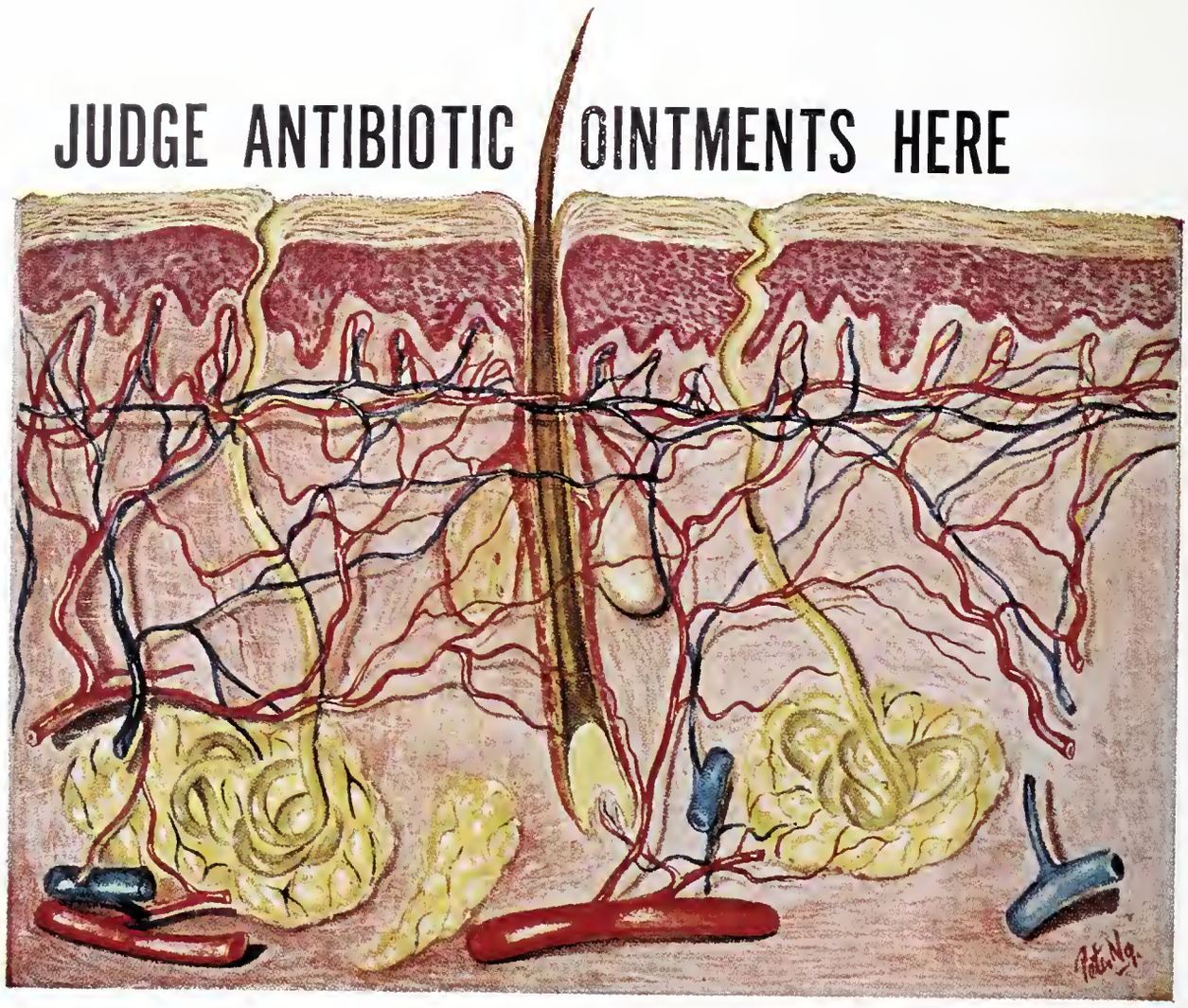
Book Reviews 199
County Society Reports 205
Hawaii Academy of General Practice 194
Hawaii Medical Association 207
In Memoriam—Doctors of Hawaii—XC 198
Inside HMA 193
Letters 160
New Members 202
Notes and News 200
President's Page 191
Slants and Angles 195
University of Hawaii 196
X-ray View Box 197

Hawaii Pharmacists' Bulletin

The President's Corner 208
Legislation 208
Drug Abuse Committee 209

Cover: From the collection of Meryl H. Haber, M.D.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand
POLYMYXIN B-BACITRACIN-NEOMYCIN
OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-107/4/71/U S PATENT NO 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contoins: Quinine sulfote, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention ond treotment of nocturnol ond recumbency leg muscle cromps, including thase associated with arthritis, diobetes, varicose veins, thrombophlebitis, arteriosclerosis ond static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce Intestinal cromps In some instances, and quinine moy produce symptoms of cinchonism, such os tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the eors, deafness, skin rash, or visuol disturbances occur. **Dosage:** One tablet upon retiring. Where necessory, dosoge may be increased to one tablet following the evening meol and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 toblets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



For her "problem feeder" ■ so white and smooth it looks like milk ■ appealing milk-like flavor ■ free from unpleasant odor ■ ot leost 25% more protein than other soy isolate formulas ■ convenient 32-fl. oz. Reody-To-Use—ovoids errors in mixing. **For Hospital Use:** NURSETTE® disposoble bottle service—4 and 8 fl. oz.; ond the BENIFLEX® disposable nurser system—32-fl. oz. cons.

Composition: 87% water, 3.9% sugor, 3.1% soy oil, 2.7% corn syrup solids, 2.7% soy protein isolate, 0.26% dicolcium phosphate, 0.26% potassium citrate, 0.10% lecithin, 0.05% calcium carbonate, 0.04% dibasic magnesium phosphate, 0.03% salt, 0.03% corrageenan, 0.03% guar gum, 0.02% DL-methianine, vitomin A polmitate, colciferal, sodium oscarbate, thiamine hydrochloride, riboflavin, niocinamide, sodium iron pyraphosphate, potassium iodide, pyridoxine hydrochloride, cyanocobolamin, calcium pontothenate, choline chloride, inositol, cupric sulfate, manganese sulfate and zinc sulfate.

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 78770

Mead Johnson LABORATORIES

When analgesia is needed for a long period

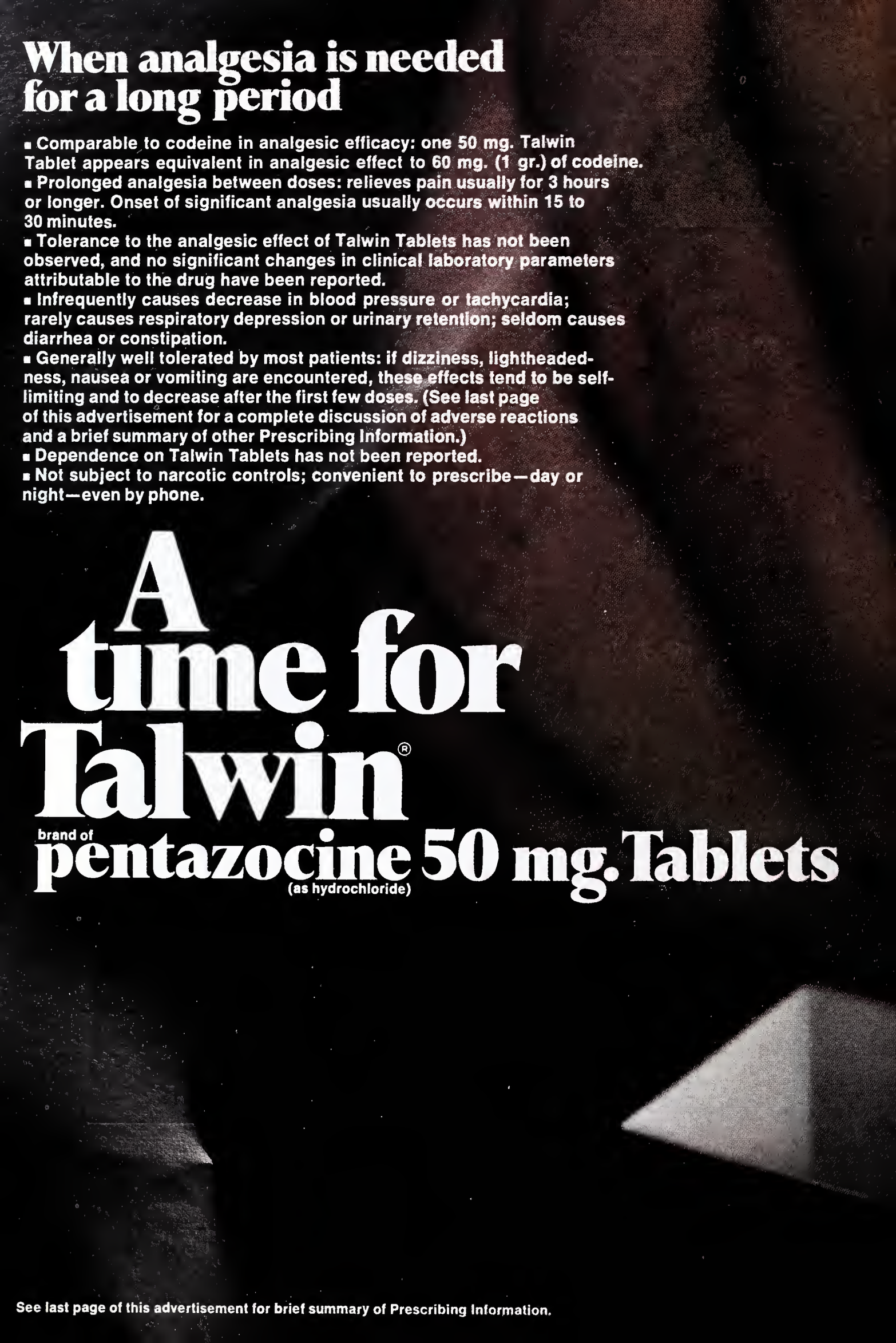
- Comparable to codeine in analgesic efficacy: one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine.
- Prolonged analgesia between doses: relieves pain usually for 3 hours or longer. Onset of significant analgesia usually occurs within 15 to 30 minutes.
- Tolerance to the analgesic effect of Talwin Tablets has not been observed, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- Infrequently causes decrease in blood pressure or tachycardia; rarely causes respiratory depression or urinary retention; seldom causes diarrhea or constipation.
- Generally well tolerated by most patients: if dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief summary of other Prescribing Information.)
- Dependence on Talwin Tablets has not been reported.
- Not subject to narcotic controls; convenient to prescribe—day or night—even by phone.

A time for Talwin®

brand of

pentazocine 50 mg. Tablets

(as hydrochloride)



See last page of this advertisement for brief summary of Prescribing Information.



moderate to severe pain-

A time for Talwin®

brand of pentazocine (as hydrochloride) 50 mg. Tablets



Contraindications: Talwin should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been no reports of dependence or of withdrawal symptoms with orally administered Talwin. Nevertheless, patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

Adverse Reactions: Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg. When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

Winthrop (1511M)

Winthrop Laboratories, New York, N.Y. 10016

A
BUILDING BLOCK
TO RECOVERY



Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple



Trichomonads . . . monilia . . . bacteria
You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC
Cream (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

Suppositories (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.14 Gm.)

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

TRADEMARK: AVC AV-104 2/71 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular



Hot spots on her bikini are one thing.

Tinea versicolor spots on her body are something else. The specific solution is TINVER®—the likeable lotion that provides a 25% sodium thiosulphate solution *without* the unpleasant odor. With TINVER, a colloidal alumina suspension allows controlled, gradual release of nascent sulphur so there's never any unpleasant odor—just pleasant acceptance by your patients. Cleansing, keratolytic salicylic acid has also been added to enhance the penetration of the fungicide and assure more dependable results.

Tinver
(sodium thiosulphate 25%, salicylic acid 1%)
The pleasant solution to tinea versicolor.

Description: Sodium thiosulfate 25%; salicylic acid 1%; isopropyl alcohol 10%; propylene glycol; menthol; disodium edetate; colloidal alumina; purified water. *Indications:* For topical use in the treatment of tinea versicolor *(Malassezia furfur* infection). *Administration:* Thoroughly wash, rinse and dry the affected areas before application of medication. Apply a thin film of lotion twice a day or as directed. Although diagnostic evidence of the disease may disappear in a few days, it is advisable to continue the treatment for a much longer period. Clothing should be boiled to prevent reinfection. *Precautions:* If signs of irritation or sensitivity develop, discontinue use. Do not use on or about the eyes. *Supply:* 5-fl. oz. and new economy 12-fl. oz. plastic squeeze bottles.

Barnes-Hind Laboratories
Subsidiary of Barnes-Hind Pharmaceuticals, Inc.
Sunnyvale, California 94086.
Makers of the *fine* line of dermatological products...Komed® HC, Barseb® HC, Tinver, and Heb®-Cort MC.


ESTROGEN
DEFICIENT
WOMAN:

You see her from 45 to 55 with

hot flushes
night sweats
fatigue
headache
palpitations
emotional distress

TREAT HER WITH PREMARIN (Conjugated Estrogens, U.S.P.). PREMARIN offers specific, effective replacement therapy for relief of menopausal symptoms—both physical and emotional—due to estrogen deficiency. It usually provides a "sense of well-being"... helps many patients maintain a more positive outlook.

KEEP HER ON PREMARIN (Conjugated Estrogens, U.S.P.). Continued use of PREMARIN after menopausal symptoms have abated can help protect against further degenerative changes related to estrogen deficiency—changes that often begin in the reproductive organs and extend rapidly to body tissues and skeleton.

REPLACEMENT THERAPY AT ANY STAGE. The estrogen deficient woman can benefit from long term replacement therapy with PREMARIN *at any stage*—whether she is 45 and suffering symptoms of the menopause... a grandmother of 60 with atrophic vaginal tissue... or an even more elderly patient with osteoporosis. PREMARIN therapy is remarkably well tolerated, and relatively inexpensive.

BRIEF SUMMARY

PREMARIN® (Conjugated Estrogens, U.S.P.).

Indication: PREMARIN is specific for replacement therapy of the estrogen deficiency state characteristic of the menopause and the postmenopause.

Caution: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

Suggested Usual Dosage: Menopausal and postmenopausal estrogen deficiency—PREMARIN: 1.25 mg. to 3.75 mg. daily, depending on severity of symptoms. Dosage should be tailored to individual needs of patient. Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

Note: If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. Continue this individualized dosage in subsequent cyclic regimen. *Failure to control bleeding or unexpected recurrence is an indication for curettage.*

Atrophic vaginitis, pruritus vulvae: Cyclically, 1.25 mg. to 3.75 mg. or more is given, depending on tissue response of individual patient.

Available in 4 potencies: *Tablets*—No. 865—2.5 mg. (purple); No. 866—1.25 mg. (yellow); No. 867—0.625 mg. (red); and No. 868—0.3 mg. (green). In bottles of 100 and 1,000.

AYERST LABORATORIES
New York, N.Y. 10017

Ayerst®

7053

therapy for all stages
of estrogen deficiency

NATURAL ESTROGEN THERAPY

PREMARIN®

BRAND OF

CONJUGATED
ESTROGENS, U.S.P.


Thorazine®
brand of chlorpromazine
versatility
quality
experience
NOW THERE'S PRICE
Smith Kline & French Laboratories SK&F

medicine is not a cut-rate field.

Too much is at stake to cut corners by cutting service. At Amfac you will find the lowest prices and the best terms consistent with the service you deserve and the standards you demand. Large, local stock. Fast, dependable four-times-a-day delivery service. 30 days to pay.

At Amfac medicine is not a cut-rate field.

MANAGER

SALES MANAGER — DRUG

MANAGER — MEDICAL EQUIPMENT

Amfac
DISTRIBUTION COMPANY
Drug Department
PHONE 533-0315

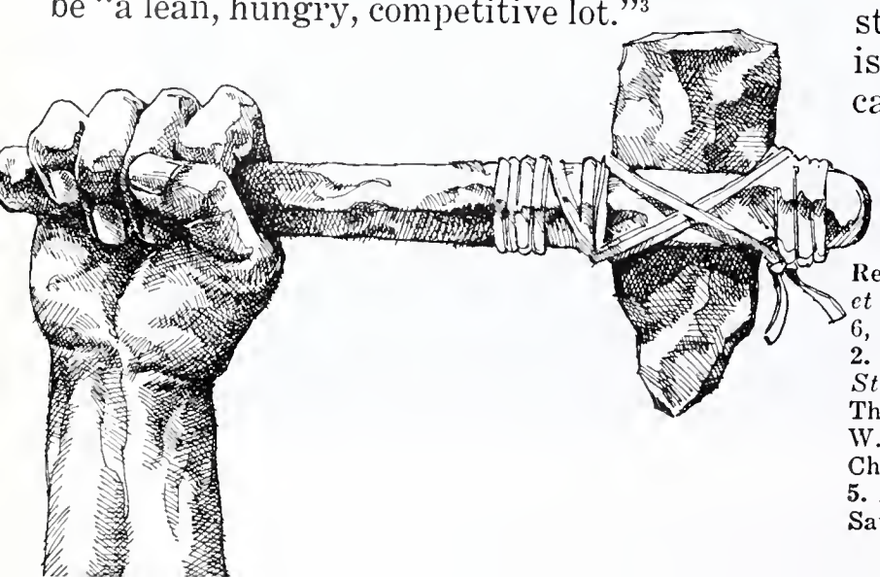
IF MORE MEN CRIED



At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.[4] Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.

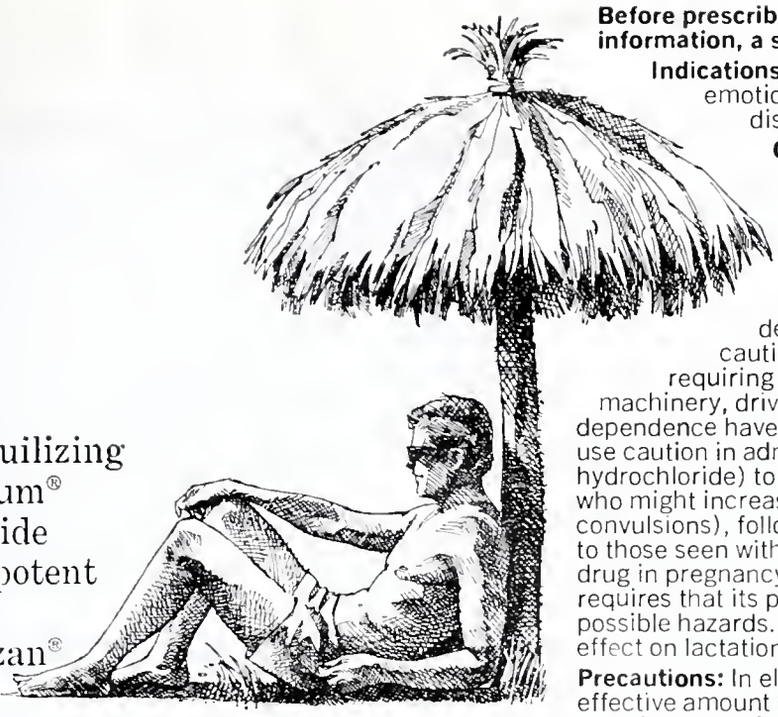


Take away stress you can take away symptoms.

There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez[5] observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax.® For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that com-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M., *et al.* (eds.): *Harrison's Principles of Internal Medicine*, ed. 6, New York, McGraw-Hill Book Company, 1970, p. 1444. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 163. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.



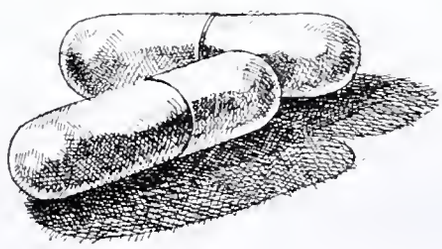
nes the tranquilizing
ction of Librium®
chlordiazepoxide
Cl) with the potent
nticholinergic
ction of Quarzan®
lidinium Br).

Protects man from his own hungry personality. The action of Librium reduces anxiety—helps protect the vulnerable patient from the psychological overreaction to stress that clutches his stomach. At the same time, the action of Quarzan helps quiet the hyperactive gut, decreasing hypermotility and hypersecretion.

An inner healing environment with 1 or 2 capsules, 3 or 4 times daily. Of course, there's more to the treatment of duodenal ulcer than a prescription for Librax. The patient—with your guidance—will have to adjust to a different pattern of living if treatment is to succeed. During this adjustment period, 1 or 2 capsules of Librax 3 or 4 times daily can help establish a desirable environment for healing.

Librax: It can't change man's nature. But it can usually make it easier for men to cope with the discomfort of stress—both psychic and gastric—that can precipitate and exacerbate duodenal ulcer.

Librax: Rx #60 1 cap. *a.c.* and 2 *h.s.*



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

in the treatment of duodenal ulcer

adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N J 07110

Letters

To the Editor:

The March-April issue of the HAWAII MEDICAL JOURNAL just came. While perusing it, I came upon the article re the Mabel Smyth Building. I did propose unification of services of the nursing and medical professions in 1934 when I was President of the Honolulu County Medical Society. I did propose a telephone service, nursing bureau, doctors' and nurses' society offices and a library. The Mabel Smyth Building resulted from the proposal. Mr. Charles Hemenway, then Chairman of the Board of Directors of Queen's Hospital, was a powerful ally. The whip and really greatest influence for the building was Mrs. Thelma Akana. She really put the project across and should be mentioned in any history of the building.

Best regards,

DOUGLAS B. BELL, M.D.

To the Editor:

It appears that you have republished in the January/February, 1971, issue of the HAWAII MEDICAL JOURNAL, the same false statement about me that appeared as a "letter to the Editor" of *The Honolulu Advertiser* on April 21, 1959, and which I have reason to believe you knew at the time to be false.

The previous statement read: "Dr. Exner of Seattle was unable to prove in court that even one single person had ever been harmed by it (fluoridated water)."

Your present version reads: "The way to know that fluoridated water might be harmful would be to know that somewhere, once upon a time, it was harmful to someone. Dr. Frederick Exner of Seattle had a couple of weeks in a Federal court in which to prove this—and he couldn't do it."

Both statements are completely and categorically false in every detail. Both were made in a deliberate attempt to mislead the citizens of Hawaii to their hurt in a matter vital to their health, liberty, and welfare. The facts are these:

Prior to a fluoridation election in Chehalis, Washington, on May 3, 1955, a group calling themselves "The Chehalis Fluoridation League" published an offer of a reward as follows:

> A REWARD OF $1000.00 CASH IS HEREBY OFFERED TO ANYONE WHO CAN PROVE THAT FLUORIDES IN ONE PART PER MILLION HAVE PRODUCED AN ILL EFFECT ON ANYONE ANYWHERE.

I wrote claiming the reward and, at a public meeting in Chehalis called for the purpose, I presented a patient of mine whose teeth had been badly stained by the water at Denver, Colorado, which he had used while the tooth-enamel was being formed. A color picture of his teeth will be found as Fig. 3, opposite page 1115 in Northwest Medicine, Volume 54, October 1955.

Dr. H. Trendley Dean, Director of the National Institute of Dental Research, and author of the official classification of "Mottled enamel" (dental fluorosis) in



terms of severity, testified to a committee of the American Medical Association that Denver water at the time contained slightly less than one part per million of fluorine, and that the said picture of this patient's teeth should be classified between "Mild" and "Moderate" as those categories had been defined by him in Public Health Reports, 50:424-442, 1935, and illustrated in the Journal of the American Dental Association 30:1278-1283, 1943.

When the League failed to pay, I sued to collect in the Superior Courts of the State of Washington (not a "Federal court"). In his Memorandum Decision the judge held that according to the dictionary, "ill" means "sick" and "effect" means "result"; and that since no witness had testified that the patient's disfigured teeth were "a sick result" I had "failed to sustain the burden of proof that an ill effect had been produced."

Moreover, he said, the stains could be removed. They can't be removed without damage to the enamel; and he didn't say why anyone would want to remove them if they were not "an ill effect." And the Washington State Supreme Court said that, although the grounds on which the decision had been based were in error, the decision would be upheld!

At no time in the proceedings was the artificial fluoridation of public water supplies at issue, nor was any harm other than that caused by Denver water to these particular teeth at issue although it was made clear that such harm to a substantial number of children must be expected wherever water supplies contain as much as one part per million of fluorine, and that the harm from artificial fluoridation is generally more severe than from fluorine naturally present.

* * *

So much for that. Now as to your statement that "The way to know that fluoridation might be harmful would be to know that somewhere, once upon a time, it was harmful to someone."

I find it impossible to believe that you are so stupid that this statement could have been published in good faith, or otherwise than as an attempt to mislead your readers. Furthermore, you have been doing this now for many years. Why, I must leave up to you.

You surely are not so stupid as to believe that the toxic effects of waterborne fluorine are governed by its concentration in the water without regard to how much water is consumed or, alternatively, that all people consume the same amount of water.

Neither are you so stupid as to believe that "no evidence of harm" is a valid substitute for "evidence of no harm."

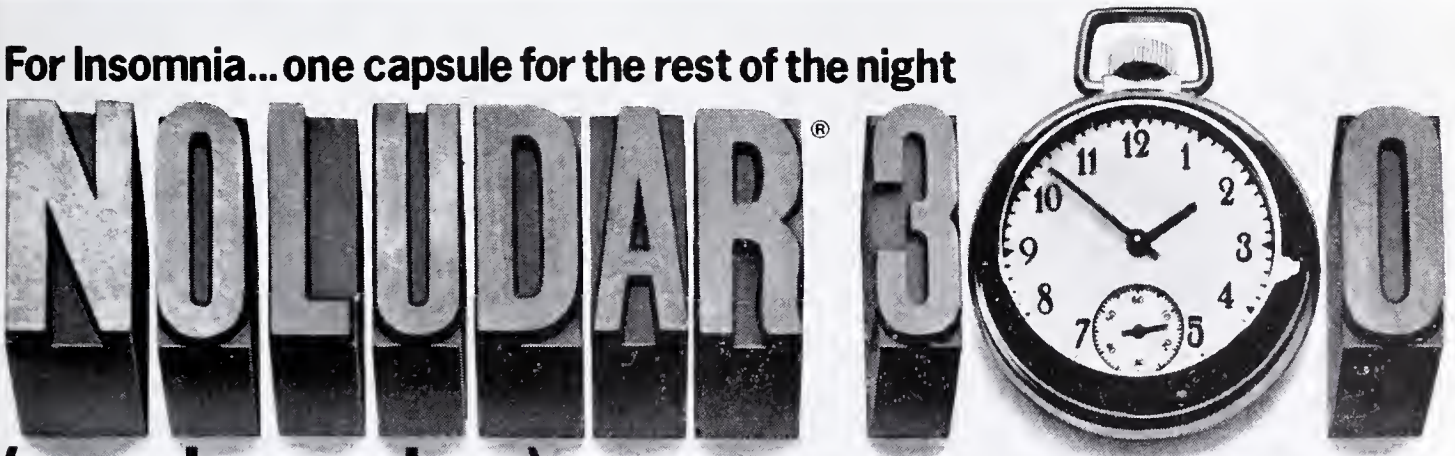
Unless you publish a full and complete retraction of the false information just published I shall be forced to make this an open letter. In fact, I would suggest that you publish my paper entitled: "Can People Be Harmed By Fluoridation?" which I shall be glad to send you.

Sincerely yours,

FRED B. EXNER, M.D., F.A.C.R.

We agree dental mottling is an "ill effect," though it seems pretty mild to qualify as "harm." It's comforting to know that this was the only "ill effect" of fluoridation Dr. Exner thought he might be able to prove, however. We regret the errors in our report of his day in court. As to other ill effects, or harm, we have yet to hear any evidence of such, aside from unsupported testimonial-type allegations. We still firmly believe, along with the vast majority of responsible physicians, biologists, chemists and other scientists, that fluoridated water is a safe and effective preventive of tooth decay.—ED.

For Insomnia... one capsule for the rest of the night



(methyprylon)

Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Now available for your prescribing needs



Cordran® Tape

Flurandrenolide Tape (4 mcg. per sq. cm.)

Additional information available upon request • Eli Lilly and Company, Indianapolis, Indiana 46206

000121

Lilly

Hiatus Hernia and Gastroesophageal Reflux

Hiatal hernia is usually a medical problem,
but its surgical repair, when needed, is not difficult.

J. JUDSON McNAMARA, M.D., *Honolulu*

Hiatus hernia rarely causes symptoms unless it gives rise to gastroesophageal reflux. This is likely to produce esophagitis, which may cause intractable pain, stricture, or bleeding, and may even produce pulmonary disease through nocturnal aspiration. Control of reflux is usually possible by medical treatment. Surgical repair is indicated when and if conservative measures fail, and it should be successful in 90% of cases.

CURRENT UNDERSTANDING of the pathophysiology of the distal esophagus has allowed a clear definition of the origin of a symptom complex generally ascribed to the anatomical abnormality of "hiatal hernia." Furthermore, it has made possible a rational and effective approach to the treatment of this symptom complex.

Hiatal hernia is an anatomical abnormality which is noted frequently in GI series.[1] Two generally recognized types occur: sliding hernias and paraesophageal hernias. The vast majority are of the sliding variety. Both occur at all ages but are more common in the older group. Hiatal hernia is usually symptomless and if so requires no treatment. When symptoms do occur they are rarely due to the hernia itself but rather to gastroesophageal reflux resulting from a breakdown in the mechanism that prevents reflux of gastric juice into the lower esophagus.

From Queen's Medical Center and Department of Surgery, Straub Clinic.

Received for publication December 18, 1970.

The major causes, then, of those symptoms previously ascribed to hiatal hernia, are either peptic esophagitis or pulmonary aspiration, resulting from the gastroesophageal reflux. The severity of reflux (and consequently the severity of symptoms) is not related to the size of the hiatal hernia, and may even be present without a demonstrable hernia.[2, 3]

Problems resulting from the herniated stomach *per se* are unusual. They generally occur only with very large hernias, and are severe, being due to acute obstruction and strangulation.[4] Surgical correction is urgent. Because of the severity of these complications, surgical repair of asymptomatic hernias involving over 50% of the stomach is recommended.[5]

PATHOGENESIS

The pathogenesis of gastroesophageal reflux is not entirely understood; indeed, even the normal mechanism of gastroesophageal competence has not been clearly established. Several factors have been proposed to account for the normal competence of the gastroesophageal junction; in actuality, probably all contribute to some degree.[4] Three in particular seem most clearly established as important.

1. A segment of intra-abdominal esophagus is felt to be important both clinically and experimentally in preventing reflux.[6, 7] The weak intra-abdominal pressure exerts an occluding influence on that intra-abdominal portion of esophagus. This is in contradistinction to the anatomy of

hiatal hernia, where the digital esophagus is in the chest and the negative pressure which occurs with respiration actually provides a distracting influence.

2. A weak, but effective sphincter mechanism has been demonstrated physiologically at the gastroesophageal junction.[8, 9] Here again, this cannot function effectively in the chest, where negative intrathoracic pressure counteracts the sphincter mechanisms.

3. The presence of an acute angle at the gastroesophageal junction is also of anatomic importance. This creates a flap valve mechanism which closes the esophagus as gastric volume increases.[10]

SYMPTOMS

Symptoms, as mentioned earlier, are nearly always related to gastroesophageal reflux. They fall into two categories: those due to esophagitis, and those relating to the respiratory system, resulting from aspiration of gastric contents. (Table 1). It is important to realize that symptoms may occur without radiologically visible hiatal hernia.

TABLE 1.—*Symptoms and complications of gastroesophageal reflux.*

	HILL[16]	SKINNER[12]	URSCHEL[11]
Number of Patients:	950-975	1030	1148
Esophageal Complications:	~85%	> 90%	> 90%
Esophagitis	46%	86%	83%
Dysphagia	----	35%	40%
Stricture	1%	19%	8%
Bleeding	9%	14%	11%
Pulmonary Complications:	34%	8%	61%

Regurgitation, heartburn, and indigestion, all with postural aggravation, are the most characteristic symptoms of esophagitis.[11, 12] The pain, though usually a characteristic retrosternal burning, may be atypical and even mimic angina pectoris.[13]

Respiratory symptoms resulting from inhalation of regurgitated gastric contents are being appreciated with increasing frequency. Pulmonary symptoms resulting from gastroesophageal reflux are reported to occur in from one-third to over one-half of patients.[11, 12, 14-16] It is difficult to prove a cause and effect relationship between gastroesophageal reflux and a patient's pulmonary symptoms. Occasionally, aspiration is so massive that it can be confirmed radiologically or by finding food material at bronchoscopy. Most frequently, however, it seems to occur at night with the patient lying flat. This removes the effect of gravity in minimizing reflux and allows gastric contents to reach the posterior nasopharynx. Gastric juice can then be microaerosolized into the trachea by the passage of air over it with respiration. The occurrence of gastroesophageal reflux to this level is frequently confirmed by patients complaining of awakening with a sour taste or a burning sensation in their throat.[11] Frequently, however, the diagnosis of aspiration due to gastroesophageal reflux is a diagnosis of exclusion in a patient with massive, radiologically proven reflux.

On this basis, careful selection of patients, whose clinical evaluation has failed to uncover a cause of their pulmonary inflammatory disease, will result in relief of pulmonary symptoms following surgical repair in over 75% of cases.[11] These results establish the validity of the relationship. Hopefully, a better method of determining the presence of chronic aspiration of small amounts of gastric juice will be forthcoming. Pulmonary problems which are frequently due to gastroesophageal reflux and aspiration include bronchitis in nonsmokers without an apparent allergic etiology, recurrent pneumonitis, late onset asthma, and hemoptysis. Other more dramatic complications occur, including lung abscess, bronchiectasis and lipoid pneumonia.[11, 12, 14, 15] Gastroesophageal reflux has been found to result in pulmonary complications most frequently in children.[17]

DIAGNOSIS

Endoscopy and x-rays have been classically utilized in diagnosing hiatus hernia. Endoscopy remains of some importance in evaluating the severity of esophagitis and esophageal stricture. Standard barium-swallow x-ray examination has proved inadequate in diagnosis. It will define anatomical hiatus hernia in many cases but gives no insight into the presence or absence of gastroesophageal reflux, the real pathophysiologic lesion. Cine-esophagoscopy will provide information regarding the swallowing mechanism, presence or absence of stricture and presence and physiologic severity of gastroesophageal reflux. Severity is judged by the height of the column of reflux and the degree of resulting esophageal distension.[16, 17]

Determination of intraesophageal pH has proved a useful adjunct in detecting significant reflux. Gastric acid determinations are advisable in most

patients as part of the initial evaluation. Esophagoscopy and bronchoscopy are performed as indicated to evaluate esophagitis and bronchitis respectively.

TREATMENT

Treatment depends on the severity of symptoms and complications. Trial on a careful medical regimen, including elevation of the head of the bed, antacids, and smaller, more frequent meals, is indicated. If treatment is effective, symptoms will disappear in a week or so. Over half of the patients can be effectively managed with medical therapy. Stricture can sometimes be successfully managed with bougienage, although this procedure carries some risk, is successful in less than half the cases, and decreases the chance of success of a subsequent surgical repair.[12]

Surgical repair of gastroesophageal reflux depends on the successful correction of the anatomic and physiologic defects. This involves liberal esophageal mobilization to allow creation of a long intra-abdominal segment, and the consequent placement of the gastroesophageal junction well below the diaphragm. Care must be taken to preserve esophageal blood supply. The gastroesophageal angle must then be reconstructed and care taken to ensure maintenance of the esophagus and gastroesophageal junction well within the abdominal cavity.

Operations to promote gastric emptying and reduce acid peptic secretion have been advocated to reduce esophagitis in conjunction with hernia repair. Recent evidence indicates the hypersecretion is found no more frequently in hiatus hernia patients than in the general population. In addition, the presence or severity of esophagitis cannot be related to the amount of gastric acid production.[20] Consequently, except in clear instances of gastric hypersecretion, hernia repair alone is adequate.

Controversy has existed with regard to the relative advisability of transabdominal and transthoracic approach. Currently reported surgical results indicate that either route is satisfactory (Table 2) and that the choice of approach should depend on individual considerations, including presence of associated intra-abdominal surgical pathology, obesity and the experience and preference of the surgeon.[4, 11, 12, 18] Relief of esophageal symptoms is achieved by surgical repair in over 95% of patients, and radiographic recurrence of reflux occurs in less than 10% with long-term follow up.[11, 12, 16]

TABLE 2.—*Results of surgical repair of gastroesophageal reflux and hiatal hernia.*

	HILL	SKINNER	URSCHEL
Number of Surgical Repairs:	149	632	372
Route of Repair	Abdominal	Thoracic	Thoracic
Follow-up Period	few months-8 years	5-18 yrs	2-21 yrs
Symptomatic Success	96%	91%	90%
Radiographic Recurrence Rate			
Hernia	1%	< 1%	2%
Reflux	6%	7%	7%

These results support the efficacy of surgical repair in treating patients with symptomatic gastroesophageal reflux in whom medical therapy has failed.

REFERENCES

1. Boyd DP: Surgery in hiatus hernia. *S Clin No Am* 44:597, 1964.
2. Hieburt CA and Belsey R: Incompetence of the gastric cardia without radiologic evidence of hiatus hernia. *J Thor and Cardiovascular Surg* 42:352, 1961.
3. Cross FS, Smith GV, Kay EB: The surgical treatment of peptic esophagitis. *J Thor and Cardiovascular Surg* 38:798, 1959.
4. Wilkins EW, Skinner DB: Surgery of the esophagus, *N.E.J.M.* 278:824, 1968.
5. Beardsley JM, Thompson WR: Acutely obstructed hiatal hernia. *Ann Surg* 159:49, 1964.
6. Belsey R: Functional disease of the esophagus. *J Thor and Cardiovascular Surg* 52:164, 1966.
7. Baue AE: Prevention of experimental reflux esophagitis without intrinsic esophageal sphincter. *Pediatrics* 43:527, 1969.
8. MacLaurin C: The intrinsic sphincter in the prevention of gastro-esophageal reflux. *Lancet* 2:801, 1963.
9. Van Derstappen G, Texter EC Jr: Response of physiologic gastro-esophageal sphincter to increased intra-abdominal pressure. *J Clin Investigation* 43:1856, 1964.
10. Johnson, HD, Laws JW: The cardia in swallowing, eructation and vomiting. *Lancet* 2:1268, 1966.
11. Urschel HC, Paulson DL: Gastroesophageal reflux and hiatal hernia. *J and Cardiovascular Surg* 53:21, 1967.
12. Skinner DB and Belsey R: Surgical management of esophageal reflux and hiatus hernia: long-term results with 1,030 patients. *J Thor and Cardiovascular Surg* 53:33, 1967.
13. Bennet JR: The differentiation between oesophageal and cardiac pain. *Lancet* 2:1123, 1966.
14. Belsey R: The pulmonary complications of oesophageal disease. *Brit J Dis Chest* 54:342, 1960.
15. Overholt RH, Voorhees RJ: Esophageal reflux as a trigger mechanism in asthma. *Dis Chest* 49:464, 1966.
16. Hill LD: Effective operation for hiatal hernia: eight year appraisal. *Ann Surg* 166:681, 1962.
17. McNamara JJ, Paulson D, Urschel HC: Hiatus hernia and gastroesophageal reflux in children. *Pediatrics* 43:527, 1969.
18. Linsman JF: Gastroesophageal reflux elicited while drinking water—(water siphonage test): its clinical correlation with pyrosis. *Am J Roentgenol* 94:325, 1965.
19. Sandmark S: Hiatal incompetence studies on mechanics and principles of examination for hiatus hernia and gastro-esophageal reflux. *Acta Radiolog Supp* 219:1-46, 1963.
20. Squire BH, Glick S, Benn A: Maximal acid output and oesophagitis in hiatus hernia. *Thorax* 23:683, 1970.

THE PISSE-PROPHET, OR, CERTAINE PISSE-POT LECTURES.

Wherein are newly discovered the old fallacies, deceit, and jugling of the Pisse-pot *Science, used by all those (whether Quacks and* Empiricks, or other methodicall Physicians) who pretend knowledge of Diseases, by the Urine, in giving judgement of the same.

By THO. BRIAN, M. P. lately in the Citie of *London*, and now in *Colchester* in ESSEX.

Never heretofore published by any man in the *English* Tongue.

Si populus vult decipi, decipiatur.

LONDON,
Printed by *E. P.* for *R. Thrale*, and are to be sold at his shop at the signe of the Crosse-Keyes, at *Pauls* gate.
1637.

Report from University of Hawaii School of Medicine

The Art and Gentle Science of Pisse-Prophecy

KENNETH D. GARDNER, JR., M.D., *Honolulu*

THE BOOK whose frontispiece is shown on the opposite page first was published in 1637.[1] Its author, Thomas Brian, took exception with all men who claimed the ability to diagnose disease by inspecting urine. The cult whose members he attacked began in pre-Hippocratic times, when healers first became aware that urine, by its color or composition, might reflect disease. Hindus recognized glycosuria by the fact that some urines attracted ants. As early as the eighth century, heating was known to produce cloudiness in urines from afflicted persons.

By the twelfth century fact became intertwined with fallacy and a new specialty of the healing art was born: It was called uroscopy. It was practiced by water-doctors, urinarians, pisse-mongers, pisse-prophets, and water-casters. They were busy, wealthy men.

Brian sought to expose these "Rouges" and "prating Empiricks"—the practitioners of uromancy during the Middle Ages. He wrote in English, not Latin, in order to reach "meere Englishmen (I meane the common people)." He drew his line of battle clearly: "I admonish you (brother Pisse-Prophet) that you be not too busie in playing the Criticke upon mee . . ." He discoursed in charming prose: "And yet (oh the pride of man, in seeming to be what he is not!) the Pisse-Prophet doth pretend, that he perceiveth all . . . things in the Water." He applied persuasive logic to his argument: "But admit that the high red colour of the Urine did always (as it doth for the most part) import a Fever, yet the Symptomes and companions of a Fever (as heat, drought, thirst, paine in the head, want of sleepe, oppression of the stomach, want of appetite, oppilation of the liver and spleene, or any one of these) are not therein to be seen, though it please his worship to play the Antick with the water, pretending there are such marks in it. . ." He was a master of graphic art, perhaps at his best in this portrayal of a "Pisse-Prognosticator" at work: ". . . I am in my Study (where haply, my name being up, I have a bed and am lying upon it, and should have laine there till noone, had I not been interrupted) and heare a great knocking at my gate, and must my selfe (in my mans absence) be faine to goe see what the matter is: so to my gate I trudge, in all precipitous hast, with a quicke pace and a sharpe look, importing greater busines than to examine a Pisse-Pot."

His book was read widely, appearing in three English and eight German editions. And yet, despite his skillful effort (and to our good fortune!) Brian failed to kill pisse-prophecy. It survives today not as uroscopy but as urinalysis. Instead of pisse-mongers, its practitioners are called nephrologists.

From the Division of Renal Disease, Department of Medicine, University of Hawaii School of Medicine.

Received for publication March 15, 1971.

In the paragraphs to follow I have exposed five lately devised tricks of the trade, in hopes that they will be used, if they are not already, by those who dabble in the pisse-pot as they practice in the more refined arenas of the medical profession.

PAPER STRIPS

Perhaps the greatest boon to the modern water-doctor are the labor-saving paper strips and "stix" which have been introduced in recent years. To the physician, the use of these aids seems simple. Their directions are brief and clear. It hardly seems possible to use them incorrectly. But used incorrectly they are. In 1962, a charming editorial entitled "Uroscopy by Noughts and Crosses" appeared in the *Lancet*.[2] It cited the experience of two Scotch physicians who reported a false negative rate of 57% when these aids were used by ward personnel in their hospital. It identified pitfalls in the use of stix and tapes: Tapes deteriorate after six months. Outdated tapes yield erroneous results. Tapes may be left soaking in urine to be on the safe side. Technicians may use the wrong end of the paper strip or place the right end in the wrong urine. Despite these pessimistic reports, however, tapes have earned a rightful place in the routine laboratory. They deserve wider application in screening for globulinuria and in aiding in the differential diagnosis of red urine at the bedside or in the office.

"DUAL TEST" FOR PROTEINURIA

Until the advent of paper strips, sulfosalicylic acid, and heat and acetic acid, were preferred methods for the detection of proteinuria. In many laboratories both now have been replaced by the paper strip. Its *modus operandi* is based on a phenomenon known for almost three-quarters of a century: the "protein error of indicators." At a fixed pH, certain indicator substances in solution may have one color when protein is present and another when protein is absent. The paper strip is impregnated with tetrabromphenol blue and citric acid. The latter is intended to reduce the pH of urine absorbed in the stick to approximately 3.0. At this pH, tetrabromphenol blue has a yellow color in the absence of protein. In the presence of protein, however, and depending upon its concentration, the dye appears yellowish-green, green, or blue. Albumin, more than the other proteins commonly found in urine, is responsible for the color which tetrabromphenol blue may display at pH 3.

In contrast are the proteins and other substances which are detected by the sulfosalicylic acid technique. They include not only albumin but also globulins (hemoglobin, myoglobin, Bence-Jones protein), antibiotics (penicillin), and drugs (PAS and tolbutamide).

Shown in Table 1 are the four combinations of reactions that are possible when urine is tested for protein using both the dip-stick and sulfosalicylic acid. A positive test with each indicates the presence of albuminuria. A negative test with both indicates the absence of albumin, globulin, and the several other substances mentioned above. A positive test with acid in the presence of a negative result with the stick suggests globulinuria, as does a significantly more intense reaction (e.g., 4+) with acid and a less intense one with the stick (e.g., 2+). To the twentieth century pissemonger, this set of results suggests Bence-Jones proteinuria, providing hemoglobinuria and myoglobinuria are absent. More refined methods, such as protein electrophoresis or immunodiffusion, are required to confirm its presence.

TABLE 1.—*Combinations of results that are possible when the "dual detection method" for proteinuria is applied.*

		Sulfosalicylic acid	
		(+)	(—)
Paper-strip	(+)	+	+
	(—)	—	+
		—	—

Finally, it is possible to encounter a positive dip-stick reaction but negative sulfosalicylic acid test. This "false positive" result occurs in the presence of highly buffered alkaline urine. Sufficient buffer will neutralize citrate in the paper strip. Thus, the pH of fluid absorbed in the paper may not fall to 3 but rather to only 4 or 5. At these higher pH's, tetrabromphenol blue does not appear yellow, but instead appears greenish-blue to blue. Under such conditions the test may be read incorrectly as indicating the presence of protein.

RED URINE

"Red urine is associated with fever."[1] This "Pisse-Maxime" is accepted less enthusiastically today than was evidently the case in Brian's time. Many things cause urine to be red. They include blood, myoglobin, porphyrins, indols, and even the pigment from beets in susceptible individuals. The dip-stick offers a ready approach to the differential diagnosis of red urine. The stick which commonly is used to detect hemoglobin contains orthotolidine and peroxide. In the presence of myo- or hemoglobin, the oxidation of orthotolidine by peroxide is catalyzed. Oxidized orthotolidine is blue. The stick is not specific since it detects organic iron in urine, in the form of either hemoglobin or myoglobin. A patient with red urine, abdominal pain, and a positive dipstick test might well have a kidney stone with hematuria. On the other hand, were he to have red urine, abdominal pain, and

a negative dipstick test, porphyria or beeturia might be preferred diagnostic possibilities.

While sensitive to free hemoglobin, which may come from the lysis of red cells in either blood or urine, the dipstick reacts poorly or not at all when only a few intact red cells are present in urine. Performing the test on the centrifuged and resuspended button of sediment increases its accuracy. This modification of the method is preferred by the modern pisse-monger. Microscopic examination of red urine completes a search for blood. Urine is not considered free of red cells unless both stick and microscopic examination are negative.

URINARY CASTS

Casts in the sediment are perhaps the most exciting formed element in the urine. They take diverse shape and form. They have a variety of content. They are easy to see under the microscope and are readily recognized by the probationary laboratory technician whose job it is to perform routine urinalyses. All too often her search stops when she finds them.

Hyaline casts are significant not for their presence but for what they contain. Their matrix is composed of mucoprotein, a substance which enters urine as it courses through the urinary tubule. Mucoproteinuria and hyaline casts when found alone have no known clinical significance, unless in the case of the cast, red or white blood cells, renal tubular epithelium, or crystals are entrapped in its matrix. It's the fruit, not the jello, that counts.

Casts of the epithelial series, in contrast, are almost always associated with proteinuria. This series includes the cellular, coarse and finely granular, and waxy casts. In them it is difficult, if not impossible, to see elements such as red or white blood cells. The broad and waxy cast is the most significant, for it forms in the lumen of a diseased nephron where tubular flow is slow or intermittent. Its presence in large numbers has been recognized as a sign of significant renal disease since urinary casts were first described 125 years ago.

The modern pisse-prognosticator searches carefully for red and white blood cell casts. The sighting of even two in a urinary specimen can be taken as definitive evidence of renal disease.

While quick to recognize their significance, nephrologists have been slow to alter the technique of urinary sediment examination in order to insure their detection. When the presence of red or white cell casts is suspected by the physician, he should look himself or notify the laboratory. A careful search then can be made for these important casts. We do this much for the cardiologist reading EKG's and the radiologist scanning films. Why not do it for the laboratory technician who must otherwise examine blindly tens to hundreds of urine specimens each day? The addition of a drop or two of 3% acetic acid to a urine sediment in which red cells are numerous will cause them to lyse and leave naked any red cell casts which might be present. This also holds true for the equally significant hemoglobin cast.

THE CLEAN-CATCH URINE

Often overlooked is the fact that the presence of many epithelial cells is presumptive evidence *against* the cleanliness of a "clean-catch" urine specimen. In their presence the significance of red and white blood cells and bacteria in the urinary sediment must be considered questionable.

The art and science of pisse-propheey still live. Perhaps some day they may reach a level of proficiency portended for them by the following anecdote: A zealous young man, desiring to escape his military obligation, hastened among the members of his household collecting urine specimens. In a single container he mixed an aliquot of urine from each person and took it with him to his preinduction physical examination. As he passed the laboratory he deposited this container by a sign which read: "Leave urine specimens here." Three weeks later he was notified as follows: "Greetings! Your grandmother has diabetes, your father has BPH, your mother has pyelonephritis, your girlfriend is pregnant, your bitch is in heat, and you, young man, are in the Army."

I hope that those who read this essay will remember that dual testing with sulfosalicylic acid and a dipstick for proteinuria enhances the diagnostic potential of screening for proteinuria; that blood should be sought both by microscopy and chemical testing in every urine specimen; that forewarning the laboratory increases its effectiveness in detecting red or white blood cell casts; that a drop of 3% acetic acid will lyse red cells and make red cell casts more easily discerned; and that the presence of many epithelial cells makes suspect the cleanliness of a clean-catch urine specimen.

As to the literary quality of this essay, I make no claims. I suspect that to it many would apply the words of Brian, who said of his own work, "As for the stile, and method of it, it is poore and mean, but such as best sutes with such a poore, base, and stinking subject."

REFERENCES

1. Brian T: The Pisse-Prophet or Certaine Pissepot Lectures, R. Thrale, London, 1637, p. 108.
2. Editorial. Uroscopy by noughts and crosses. *Lancet* 1:413-414, 1962.

Rheumatoid Factor and Antinuclear Antibody in Systemic Lupus Erythematosus, Rheumatoid Arthritis and Infectious Mononucleosis

Rheumatoid factor and antinuclear factor may occur in infectious mononucleosis as well as in LE.

CARL K. ICHIDA and MITSUO YOKOYAMA, M.D., *Honolulu*

Serum samples from 53 patients with rheumatoid arthritis, 23 patients with systemic lupus erythematosus, and 19 patients with infectious mononucleosis were tested for the presence of the rheumatoid factor (RF) and antinuclear factor (ANF), using the RA-Latex globulin test and a modified version of the Coons immunofluorescent antibody technique.

Serological overlap was demonstrated in these patients with both the RA-Latex globulin test and the immunofluorescent antibody test.

AUTOIMMUNITY is believed to play a role in the pathogenesis of the systemic connective tissue diseases: rheumatoid arthritis (RA) and systemic lupus erythematosus (SLE). The presence of a factor (RF) in rheumatoid serum capable of reacting with gamma globulin (IgG) from different species, including man,[1] and the antibody in LE serum against nuclear materials (ANF)[2, 3] provided evidence to support the view of autoimmunity.

The present study investigated the incidence of the RF in the sera of the patients with clinically diagnosed rheumatoid arthritis and the incidence of the ANF in LE sera. The ANF was further characterized as to its immunological specificity and whether or not different nuclear staining patterns could be produced by different antibodies.

The sera of patients with infectious mononucleosis (IM) were also obtained to study the serological overlap in the demonstration of the RF and ANF among the diseases RA. SLE and IM.

MATERIALS AND METHODS

A total of 95 serum samples were obtained from hospitals, clinics, and physicians in the Honolulu area. All materials were kept at –20°C. prior to use.

Before any of the tests were conducted all the serum samples were filtered through a 0.45 μ pore Millipore filter (Millipore Co., Bedford, Massachusetts).

Latex-globulin reagent was obtained from Hyland Laboratories, Los Angeles, California, and each serum sample was initially tested with a 1:20 dilution. The tests were carried out according to the manufacturer's instructions and the control sera were also tested.

The strength of agglutination of the latex particles was graded on a scale from O to ++++.

Kuakini Medical Research Institute, 347 N. Kuakini Street, Honolulu, Hawaii 96817.

This study was supported through a Straub Medical Research Institute grant and in part by the Mrs. Lois A. Mayers Memorial Fund.

Received for publication February 24, 1970.

Those serum samples that showed a flocculation of ++ or more in the 1:40 dilution were further tested with greater dilutions.

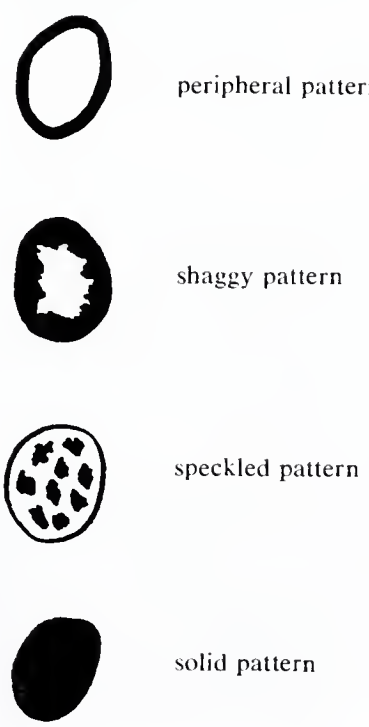
Procedure for indirect method for demonstration of antinuclear factor (ANF)[4]: fluorescein-isothiocyanate-conjugated rabbit anti-human IgG was prepared in our laboratory. Goat antiserum to human IgA and IgM, conjugated with fluorescein, was obtained from Hyland Laboratories.

Peripheral blood from a Group O Rh-negative normal man was used as the substrate for the immunofluorescence test throughout this study.

Blood smears were prepared on microscope slides and the slides were soaked in 70% methanol for five minutes following the air drying. The patient's serum was placed on the slide and incubated at 37°C for 1 hour. The slides were washed in phosphate buffered saline, pH 7.4 and dried with filter paper. Fluorescein-conjugated antiserum was applied and the slides were again placed in an incubator at 37°C for 1 hour. The slides were washed with buffered saline and air dried at room temperature. The samples were then examined under a fluorescence microscope.

The staining patterns were classified (Fig. 1) according to Barnett[5] into three types: (1) peripheral (sub-classified as shaggy in this study), (2) speckled, and (3) solid or homogeneous.

FIG. 1.—*Classification of positive patterns in nucleus as seen under a fluorescent microscope.*



RESULTS

The RA-Latex globulin test was positive in 46 (87%) out of the 53 serum samples from the patients with RA. Fourteen of the positive sera showed a flocculation of ++ or greater with the 1:40 dilution and three with the 1:60 dilution. None of the sera were positive at a 1:100 dilution.* Eight (35%) of the 23 serum samples of SLE were positive at a 1:20 dilution and six showed a positive reaction at a 1:40 dilution. None of these samples were positive at dilutions of 1:60 or 1:100. The serum samples of IM showed a lower incidence of positive reactions; only one sample demonstrated a positive reaction at a 1:40 dilution.

Nineteen (83%) cases out of the 23 SLE patients' sera showed a positive immunofluorescent nuclear reaction with leukocyte materials. The pattern with the anti-IgG serum was predominantly solid and speckled while the anti-IgA showed peripheral and shaggy patterns (Table 1).

TABLE 1.—*Incidence and titer of RA factor in rheumatoid arthritis (RA) systemic lupus erythematosus (SLE) and infectious mononucleosis (IM) sera.*

	1:20	1:40	1:60	1:100
RA (53 cases)				
positive*	46 (87%)	14	3	0
negative	7 (13%)			
SLE (23 cases)				
positive	8 (35%)	6	0	0
negative	15 (65%)			
IM (19 cases)				
positive	4 (21%)	1	0	0
negative	15 (79%)			

* Positive reaction (for all cases except RA 1:20 dilution) = flocculation = ++.

Six of the positive sera showed reactions with a combination of anti-IgG and anti-IgA sera and distribution of the reaction patterns was similar to that produced by a single antiserum. Only one serum reacted with three various antisera to produce different reaction patterns (Table 2).

The reaction patterns of the positive RA with either anti-IgG and anti-IgA sera showed similar shaggy and speckled patterns.

No antibody was found in either SLE or RA sera with a single anti-IgM serum or a combination of anti-IgG and anti-IgM or anti-IgA sera. Three IM sera (16%) produced both peripheral

* After this study was completed three serum samples of RA patients showed a titer of higher than 1:2048.

TABLE 2.—*Incidence and patterns of antinuclear factor in systemic lupus etrythematosus (SLE), rheumatoid arthritis (RA), and infectious mononucleosis (IM) sera using immunofluorescent antibody test.*

DISEASE	INCIDENCE	REACTING REAGENT	REACTION PATTERN peripheral	shaggy	speckled	solid	total
SLE (23 cases)	pos. (19 cases: 83%)	Anti IgG	0	1	3	5	9
		Anti IgA	2	1	0	0	3
		Anti IgG	1	0	2	3	6
		Anti IgA	4	1	1	0	
		Anti IgG	0	1	0	0	1
		Anti IgA	1	0	0	0	
		Anti IgM	0	0	0	1	
	neg. (4 cases: 17%)						
RA (53 cases)	pos. (22 cases: 42%)	Anti IgG	0	3	3	0	6
		Anti IgA	0	2	4	0	6
		Anti IgG	0	5	3	0	8
		Anti IgA	0	7	1	0	
		Anti IgG	0	1	0	0	1
		Anti IgA	0	0	1	0	
		Anti IgM	0	1	0	0	
	neg. (31 cases: 58%)						
IM (19 cases)	pos. (3 cases: 16%)	Anti IgG	2	1	0	0	3
		Anti IgA	1	2	0	0	
	neg. (16 cases: 84%)						

and shaggy patterns with a combination of anti-IgG and anti-IgA sera.

DISCUSSION

The incidence of the RA factor was found to be 2 to 5%[6, 7] in the sera of a normal population in different geographic areas. Shippey[8] found a 5.7% incidence with the latex test and a 8.6% incidence with the passive hemagglutination test in 1,032 men (non-rheumatoid subjects, aged 45-65) in the Honolulu area.

In this study, the incidence of the RA factor was 87% (46 out of 53 cases) in clinically diagnosed RA sera, using a 1:20 serum dilution. Fourteen of the 46 positive sera showed flocculation at serum dilutions of 1:40 and three cases were still reactive at 1:60 dilution. The incidence of the RA factor in SLE and IM sera was lower as compared to the RA sera. The present results revealed that the immunological test is of diagnostic value, with a high correlation for RA. However, there is an immunological overlap with an incidence of 35% positives in SLE and 21% in IM, which is still higher than the incidence in normal population.

Barnett[5] found that a bright, solid, homogeneous pattern of immunofluorescence is indicative of an antibody to nucleoprotein, a speckled pattern indicative of an antibody to a saline-soluble protein associated with RNA, and a shaggy pattern indicates an antibody to DNA. Friou[9] likewise found a significant correlation between the presence of the shaggy pattern and the presence

of anti-DNA as indicated by the complement fixation test.

In the present study, anti-IgG gave a higher incidence of speckled and solid forms when the SLE serum was used. Anti-IgM showed a solid form although there was only one case. Ritchie[10] reported that homogeneous and speckled patterns were chiefly the result of IgG and IgM immunoglobulins, respectively. In systemic lupus erythematosus, Barnett[5] had found high titers of antinuclear antibodies in the IgG class of immunoglobulins. The present study supports their findings, in that the positive solid pattern was predominantly found in the IgG fraction. However, SLE patients showed a high incidence of the peripheral staining pattern due to an IgA antibody.

Barnett[5] further reported the presence of antinuclear antibodies in the serum of patients with rheumatoid arthritis; these are believed to be the result of inflammatory (arthritic) processes. The antinuclear antibodies in the IgG class in RA patients were in low titers but were fairly high in the IgM class. However, there was only one serum sample from an RA patient in this study that showed a positive (solid) pattern in the IgM component, and the antibodies found were predominantly in IgG and IgA fractions, with shaggy and speckled patterns. This may be explained by the fact that most of the materials were obtained early in the course of the disease and the molecules demonstrating specificity for the antinuclear factor may not have yet become well established.

Tan[11] described these patterns similarly and had also shown that serum bearing a particular pattern can exhibit a different pattern when it is serially diluted. He concluded that this may be due to different antibodies interfering with the reactivity of other antibodies.

The present study demonstrated the presence of RF and ANF in the serum of patients with infectious mononucleosis appearing in a lower incidence than in the RA and SLE sera. The results showed immunological overlap in infectious mononucleosis and suggested that immune reactions may similarly show some immunological processes.

REFERENCES

1. Ziff M: The agglutination reaction in rheumatoid arthritis. *J Chronic Dis* 55:644-667, 1957.
2. Barnett EV and Vaughan JH: Antinuclear antibodies in rabbit antisera. *J Exper Med* 123:733-747, 1965.
3. Robbins WC, Homan HR, Deicher H *et al:* Complement fixation with cell nuclei and DNA in lupus erythematosus. *Proc Soc Exp Biol and Med* 96:575-579, 1957.
4. Coons AH: Fluorescent antibody methods. *General Cytochemical Methods.* Academic Press Inc., New York, 1958.
5. Barnett EV: Antinuclear antibodies and neuclear antigens, *NIH Information Exchange Group,* No. 5, 1966.
6. Glynn LE: *Rheumatoid arthritis and the rheumatoid factor.* Editors: P. G. H. Gell and R. R. A. Coombs. Blackwall Scientific Publications, 1962, pp. 593-610.
7. Christian CL: Rheumatoid arthritis: Edited by M. Samter and H. L. Alexander, *Immunological Diseases,* Little, Brown, and Co., 1965, pp. 725-736.
8. Shippey M and Yamakido M: Incidence of anti-γ globu'in factor in the Japanese male population of Honolu u. *Kuakini Med Bull,* Spring Issue, IV:13-16, 1969.
9. Friou GJ: Antinuclear antibodies: Diagnostic significance and method. *Arthritis and Rheumatism* 10:151-159, 1967.
10. Rtchie RF: Two new antinuclear antibodies: Their relationship to the homogeneous immunofluorescent pattern. *Arthritis and Rheumatism* 11:37-43, 1968.
11. Tan EM: Relationship of nuclear staining patterns with precipitating antibodies in systemic Lupus Erythematosus. *J Lab and Med* 70:800-812, 1967.

Orthopedic Ecology

The infused young orthopedic surgeon is well versed in re fusing backs.
The confused middle-aged orthopedic surgeon is well versed in re-fusing backs.
The defused old orthopedic surgeon is well versed in refusing backs.
Ergo, the land is profuse with refuse.

CHRISTOPHER A. MASON, M.D.
Los Angeles

California Medicine, Vol. 114, No. 1, January, 1971.

Three Months' Experience with Thiothixene

A useful new drug for schizophrenia.

JUAN CARLOS DE TATA, M.D., *Honolulu*

Six male and four female patients diagnosed as chronic schizophrenics served as subjects in the study of thiothixene (Navane) as an antipyschotic agent. Maximum dosage of thiothixene was 20 mg, qid. All but two of the subjects demonstrated improvement in sociability, interest in work, and ward functioning. Treatment for those two was not continued because of serious side effects. Generally, improvement was marked enough to warrant serious consideration of thiothixene in the treatment of schizophrenic patients.

THE EFFECTIVENESS of thiothixene in the management of both chronic and acute schizophrenic patients has been reported in various studies during the past few years. Thiothixene, a derivative of thioxanthene, is a relatively new antipsychotic agent. In numerous clinical trials, thiothixene is reported to have produced improvement in hallucinatory behavior, irritability, social competence, and personal neatness. "Particularly notable is the ability of the drug to improve alertness and increase the degree of purposeful effort and activity in chronically ill, apathetic psychotic patients. Patients for whom prior therapy has failed may respond significantly to thiothixene."[1]

Acting Chief, Diamond Head Mental Health Center, Honolulu, Hawaii.

Received for publication September 24, 1970.

STUDIES ELSEWHERE

Studies conducted within the past ten years provide positive indications of the effectiveness of thiothixene.

1. At Crownsville State Hospital, Crownsville, Maryland, thiothixene was administered to 12 chronic schizophrenic and 10 acute psychotic patients of both sexes ranging in age from 23 to 61 years of age. Treatment lasted six weeks with maximum dosage (40 mg daily) administered for the last three weeks. Moderate to severe extrapyramidal reactions were seen in less than one-quarter of the patients at increased dosage levels. The maximum improvement in both groups of patients was observed at the end of the fourth week.[2]

2. Thiothixene was administered to a large group of chronic psychotic patients for a period of one year at East Louisiana State Hospital, Jackson, Louisiana. Subjects were 144 psychotic patients (Caucasian and Negro, men and women), of whom 135 completed the entire year of treatment. The results "support earlier findings in suggesting that thiothixene is at least as efficacious as the phenothiazine compounds which are currently most commonly used with psychotic patients."[3]

3. A study of the value and safety of thiothixene administered to chronic schizophrenic patients for one year was carried out at Rockland State Hospital, Orangeburg, New York. Thirty male pa-

tients, all diagnosed as suffering from schizophrenia but otherwise in good physical health, were selected. They ranged in age from 25 to 57 years; length of hospital stay ranged from two to 26 years. The principal side effects were extrapyramidal in origin. The results "indicate that thiothixene is an active neuroleptic agent with promising therapeutic effects . . . it is possible to use it safely for one year."[4]

4. A study designed to evaluate the effectiveness of thiothixene on newly admitted schizophrenic patients was carried out with 20 such patients at the Psychiatric Division, Bellevue Hospital, New York, N.Y. The patients ranged in age from 20 to 49; all were in good physical health. The dosage was 53 mg per day as the mean maximum and 45 mg per day as the mean optimum, or best-tolerated dose. The mean number of days was 30. Two patients were markedly improved, seven were moderately improved, two were unchanged, and two became worse. Twelve of the 20 patients were discharged at the end of the treatment period.[5]

LOCAL NEED

The promising results of these studies as well as those of numerous other reports prompted the present investigation of the use of thiothixene in the treatment of schizophrenic patients. The significance of such a study is underscored by the prevalence of diagnosed schizophrenic patients in the populations of mental hospitals. At the Mental Health Unit of Leahi Hospital, the location of the present study, the major cause of hospitalization is schizophrenia. This category accounted for 75% of the 39 patients who constituted the original patient population in 1965. In the same year, schizophrenia was the diagnosis for 65% of the patient population at the Hawaii State Hospital and 73% of the population at the Diamond Head Unit of the Hawaii State Hospital.

METHOD

Subjects. Subjects were six men and four women, diagnosed as chronic schizophrenics. At the time of the study, subjects were resident patients of the Mental Health Unit of Leahi Hospital in Honolulu, Hawaii, and ranged in age from 22 to 53 years old with a median age of 32. All subjects had received previous treatment with other drugs and eight had previously been admitted to the State mental hospital. The number of previous admissions ranged from one to seven, with a median of three. Selection was based on each subject's need to increase activity as evaluated by the attending psychiatrist. Patients demonstrating violent or uncontrollable behavior were not considered for the study.

Procedure. The initial dosage of thiothixene was determined by the doctor's evaluation of need for motivation. The level of subsequent dosages was determined by the subject's response to the drug until a maximum of 20 mg qid was reached. Improvement was recorded through daily nursing observations noted on index cards and later transferred to a general form for the evaluation of psychotropic drugs. The latter was a check-off list on which could be indicated the diagnosis, most effective daily dosage, chief complaints, degree of improvement (marked, moderate, mild, none) for 55 specific signs and symptoms, degree of severity

TABLE 1.—*Summary of degree of improvement for eight* patients under thiothixene therapy.*

SIGNS & SYMPTOMS	NO. WITH SYMPTOMS	TOTAL SHOWING IMPROVEMENT	DEGREE OF IMPROVEMENT			
			Marked	*Moderate*	*Mild*	*None*
1. Flat, lifeless	7	7	0	3	4	0
2. No interest in work	7	7	1	4	2	0
3. Judgment impairment	7	3	0	0	3	4
4. Delusions	7	3	0	1	2	4
5. Somatization	6	3	1	1	1	3
6. Anxiety, tension	6	5	2	0	3	1
7. Agitation	6	5	2	1	2	1
8. Withdrawn	6	5	0	4	1	1
9. Seclusive	6	5	0	4	1	1
10. Dissociation	5	3	0	2	1	2
11. Hallucinations	5	3	0	0	3	2
12. Sloppy	5	4	0	1	3	1
13. Grooming	4	1	0	1	1	2
14. Hypoactive	4	4	0	1	3	0
15. Irritable	4	3	1	1	1	1

* Does not include patients who did not complete treatment.

of side reactions (minimal, moderate, severe) for 19 specific side reactions, and the overall clinical judgment of improvement (marked, moderate, mild, none).

RESULTS

In eight of the ten subjects, there was improvement in sociability, interest in work, and ward functioning. For two, medication was discontinued because of serious side effects. Improvement was demonstrated in at least half of the eight subjects, i.e. four or more subjects, for eight signs and symptoms (Table 1). These were flatness and lifelessness, no interest in work, anxiety and tension, agitation, withdrawing tendencies, seclusiveness, sloppiness, and hypoactivity. Improvement in at least three subjects was demonstrated for six signs and symptoms, which were judgment impairment, delusions, somatization, dissociation, hallucinations, and irritability. Overall clinical judgment was evaluated as marked for one subject, moderate for four subjects, mild for three. Side effects were present in three cases.

SUMMARIES OF INDIVIDUAL CASES

Patient 1. A 47-year-old man, diagnosed as schizophrenia, hebephrenic, was administered increasing dosages of thiothixene (Navane) ranging from 5 to 60 mg over a three-month period. Additional medication consisted of 3 mg benztropine mesylate (Cogentin) od. Reactions to previous medication, chlorprothixene (Taractan), were nonfunctioning behavior, compulsivity, changing behavior, and insomnia. Reactions to present treatment included functioning without prodding and improved sleep pattern. Overall improvement was judged to be mild. No side effects were observed.

Patient 2. A 39-year-old man, diagnosed as schizophrenia, chronic undifferentiated, received increasing dosages ranging from 10 to 80 mg over a two-month period. No additional medication was administered. Reactions to previous medication, trifluoperazine (Stelazine), were quietness, nonparticipation, and otherwise adequate functioning. Reactions to present treatment were participation to some extent in group meetings and increased pleasantness. Overall improvement was judged to be moderate. No side effects were observed.

Patient 3. A 31-year-old man, diagnosed as schizophrenia, chronic undifferentiated, received dosages of thiothixene increasing from 10 to 80 mg over a two-and-a-half-month period. No other medication was administered. Reactions to previous medication, chlorprothixene (Taractan), included bizarre behavior, inability to function in ward routine, and quietness. Reactions to present treatment included increased sociability and verbalization. Patient lapsed into acute psychosis for approximately two days, after which he returned to behavior obtained with 40 mg daily dosage of thiothixene. Promazine (Sparine), IM, prn, was administered during the acute state. Overall improvement was judged to be mild. No observed side effects.

Patient 4. A 33-year-old man, diagnosed as schizophrenia, hebephrenic, was administered two dosages of thiothixene (60 and 80 mg) separated by a two-day interim. No additional medication was used. Reactions to previous medication, chlorpromazine (Thorazine), were escape tendencies, flatness, poor ward performance, and hallucinations. Reactions to present treatment included decreased escape tendencies, increased sociability, and functioning without prodding. Overall improvement was judged to be moderate. No side effects were observed.

Patient 5. A 23-year-old woman, diagnosed as schizophrenia, chronic undifferentiated, was administered gradually increasing dosages of thiothixene ranging from 8 to 80 mg over a month's period. Additional medication consisted of Ovulen (1 tablet od), atropine (0.6 mg od). Reactions to previous medication, chlorpromazine (Thorazine), included delusions, poor ward functioning, and lack of interest. After treatment patient demonstrated increased interest, better ward functioning, and a slight decrease in escape tendencies. Overall improvement was judged to be moderate. Side effects, occurring at a dosage of 80 mg, consisted of rolling of eyes, which was controlled with atropine.

Patient 6. A 31-year-old man, diagnosed as schizophrenia, paranoid, was administered dosages of thiothixene ranging from 30 to 80 mg, increased over a one-week period. Additional medication included benztropine mesylate (Cogentin), 6 mg od. Reactions to previous medication, chlorprothixene (Taractan), included anxiety, irritability, homicidal thoughts, and agitation. Reaction to treatment included marked improvement in headache complaints, anxiety, tension, agitation, suicidal tendencies, self care, irritability, and manneristic behavior. Moderate improvement occurred in tendencies toward delusions, dissociation, somatization, depression, listlessness, fatigue, and with-

drawn behavior. Overall improvement was judged to be moderate. Side effects included moderate agitation and anxiety at 30-mg dosage, complaints of hotness at 40 mg, and photosensitivity at 80 mg. With a 6-mg dosage of benztropine mesylate (Cogentin), side effects decreased.

Patient 7. A 22-year-old woman, diagnosed as schizophrenia, chronic undifferentiated, received increasing dosages of thiothixene ranging from 6 to 80 mg over a period of one month. Additional medication consisted of Ovulen (1 mg od). Chief complaints before treatment were poor ward functioning, escape tendencies, lack of interest in work, hypoactivity, and listlessness. Reactions after treatment included slightly increased interest, increase in work, slight improvement in ward functioning, but continued escape tendencies. Overall improvement was judged to be mild. No side effects were observed.

Patient 8. A 27-year-old woman, diagnosed as schizophrenia, chronic undifferentiated, was administered dosages of thiothixene ranging from 10 to 80 mg over a two-month period. Additional medication consisted of benztropine mesylate (Cogentin), 4 mg od. Reactions to previous medication, chlorprothixene (Taractan), included antisocial behavior, delusions, frequent elopement, anxiety, and tension. Reactions after treatment included increased sociability, functioning at highest level, and no elopement tendencies. Overall improvement was judged to be marked. Observed side effects consisted of insomnia, restlessness, and "sick talk." Benztropine mesylate (Cogentin) was used to control the side effects, and the dose was later decreased.

Patient 9. A 53-year-old man, diagnosed as schizophrenia, paranoid, was administered 15, 20, 30 mg of thiothixene, with each dosage separated by a two-day interim. Additional medication consisted of methylphenidate (Ritalin), 60 mg od during treatment. Post treatment medication consisted of meprobamate, 1600 mg, methylphenidate (Ritalin), 30 mg and later 60 mg od. Reactions to previous medication, thioridazine (Mellaril) and imipramine (Tofranil), included acute depression, escape tendencies, delusions, and poor ward functioning. There was no observable improvement as a result of treatment. Side effects consisted of restlessness at 20-mg dosage. Methylphenidate (Ritalin) was administered in conjunction with thiothixene (Navane) at this time. Functioning remained poor. At 30 mg of thiothixene, cardiac arrhythmia was observed. All medication was discontinued.

Patient 10. A 46-year-old woman, diagnosed as schizophrenia, chronic undifferentiated, received increasing dosages of thiothixene ranging from 15 to 50 mg over a one-and-a-half-week period. Additional medication consisted of atropine (0.3 mg tid, 0.9 mg od). Reactions to previous medication, trifluoperazine (Stelazine) and chlorpromazine (Thorazine), included "sick talk," delusions, increased bizarre behavior, and inability to function. There was no observable improvement as a result of treatment. Side effects included temperature elevation, nonfunctional and bizarre behavior, and tremors. At this time thiothixene was withheld. Subsequent effects were drooping of side of mouth, flushing, cogwheel signs, and fine tremors. Atropine was administered (0.3 mg tid). During the ensuing four days, 10 mg of thiothixene was administered only when symptoms decreased. All medication was discontinued.

DISCUSSION

Results of this study give support to previous research indicating the successful use of thiothixene (Navane) for schizophrenic patients. Although side effects in two cases were sufficiently severe to discontinue treatment, the improvement demonstrated in the eight remaining subjects in sociability, interest in work, and ward functioning was marked enough to warrant serious consideration of thiothixene in the treatment of schizophrenic patients.

REFERENCES

1. Physicians' Desk Reference, 23rd ed, Medical Economics, Inc, Oradell, N.J., 1969.
2. Kurland AA, Pinto A, Dim BH, *et al:* Pilot study of Navane (thiothixene) in chronic schizophrenics and acute psychotic patients. *Curr Ther Res* 9:298-304, 1967.
3. Bishop MP, Gallant DM, Steele CA: Extended trial of thiothixene in chronic psychotic patients. *Psychiatry Digest* 29:15-22, 1968.
4. Angus JWS, Iqbal F, Iqbal J, *et al:* A year's trial of thiothixene in chronic schizophrenia. *Internat J Neuropsych* 3:408-411, 1967.
5. Hekimian LJ, Gershon S, Floyd A Jr: Some clinical and physiologic effects of a thioxanthene derivative, thiothixene (P-4657B), in 20 newly hospitalized male schizophrenics. *J Clin Pharmacol* 7:52-57, 1967.

Thiothixene in Chronic Schizophrenia

A Clinical Trial

Very encouraging results are reported with a new antipsychotic drug, thiothixene.

A. HAMDI YILMAZ, M.D., *Honolulu*

Thiothixene is an excellent choice for the treatment of acute and chronic schizophrenic patients who fail to respond to two popular antipsychotic drugs, chlorpromazine and a chlorpromazine-trifluoperazine combination.

Of 50 randomly selected patients in our study, 10 had acute schizophrenia and 40 were chronic schizophrenics. On an average daily dosage of about 30 mg thiothixene (from 10 to 60 mg), 15 patients (30%) showed a marked improvement, 20 (40%) demonstrated moderate improvement, and six (12%) showed slight improvement. Eight patients remained unchanged, and one patient became worse during treatment. The drug was discontinued in 17 patients: 13 because of extrapyramidal reactions, and four because they were not responding to the drug. At the conclusion of the study 14 patients (28%) were discharged from the hospital.

DURING THE PAST 15 years, no other single treatment approach to schizophrenia has proven itself as consistently effective as the use of psychotropic agents.

Antipsychotic drugs have revitalized hospital care of the mentally ill. While a major impact has been on the chronic wards, whose patients often have been enabled to leave one hospital and return to the community, these drugs have made short-term hospitalization of schizophrenic patients an increasingly common phenomenon. Another significant development has been that non-psychiatric physicians have been encouraged to undertake treatment of schizophrenic patients.

Yet, despite such major progress, a number of problems confront the hospital psychiatrist as well as the physician in private practice. As an example, a disadvantage of most antipsychotic drugs is that they cause extrapyramidal reactions, such as parkinsonism, at the same time as they improve psychoses. At this time, there are six known chemical classes of antipsychotic compounds, but only three have been sufficiently developed and tested to permit clinical use. These three are the derivatives of phenothiazine, butyrophenone and thioxanthene. Because they have been in use for so long and have become so popular, the phenothiazines constitute the most frequently used antipsychotic agents—three subgroups that include eleven drugs. Chlorpromazine, thioridazine, and trifluoperazine are the best known and most widely used. But, unfortunately, they are not universally effective, and patients' tolerance to them is variable.

Often a problem arises in the selection of a suitable successor to these drugs. Hollister[1] has

Chief, Rural Oahu Unit, Hawaii State Hospital.
Received for publication August 10, 1970.

pointed out that no evidence supports the superiority of any combination of drugs over the proper use of a single drug. He suggests that the most rational way to narrow the choice of a psychopharmacologic agent is to master one of each of the three types of phenothiazine, a butyrophenone, and one of the two thioxanthenes.

Since thiothixene* in a number of clinical trials[2-7] has been found as effective as some phenothiazines in both acute and chronic schizophrenia, this drug was chosen for treatment of 50 randomly selected patients. These patients were treatment failures, not having responded to either chlorpromazine or a combination of chlorpromazine and trifluoperazine. The aim of this study was to determine if thiothixene would provide relief to patients who had been unresponsive to or intolerant of phenothiazine derivatives, to determine how quickly effective results could be achieved, and also to observe the incidence of extrapyramidal reactions.

MATERIAL AND METHODS

Subjects. Fifty schizophrenic patients randomly selected from the four Units of Hawaii State Hospital were included in this study. These patients hailed from the Diamond Head district, downtown Honolulu and rural Oahu, as well as from the neighboring islands of Guam and Samoa. A number of different ethnic backgrounds (Tables 1 and 2) were represented. There were 31 men and 19 women whose ages ranged from 13 to 56; the average age was 37.3 years. Patients had been hospitalized from three days to 40 years prior to this study. All but five patients had been maintained on another antipsychotic drug (chlorpromazine, chlorpromazine-trifluoperazine) prior to being switched to thiothixene.

Five men and five women whose ages ranged from 13 to 47 composed one group of 10 acute schizophrenic patients. Among them, one acute patient had been diagnosed as acute paranoid, four as acute undifferentiated, one as acute simple, and one as acute childhood schizophrenia. The 40 chronic schizophrenics included 26 men and 14 women whose ages ranged from 22 to 56. The schizophrenic subgroups represented among these chronic patients were paranoid (18), catatonic (9), undifferentiated (5), simple (3), hebephrenic (3), and schizoaffective (2). As a group, the 10 acute patients were somewhat younger: their average age was 30.7 years, compared to the chronic patients whose average age was 38.9 years.

Of the 50 patients, 45 had failed to respond to conventional therapies or previous medication on which they had been maintained from one week to 10 years. On a previous global rating scale, with improvement rated as moderate, little, or none, 10 patients had been classified as showing no improvement and 35 patients had been rated as having shown little improvement. Of the remaining five patients, three patients were newly admitted, having been in the hospital for only three or four days before participating in the thiothixene trial. Two patients received no medication. Interestingly enough, these two patients were a 53-year-old man with chronic simple schizophrenia who had been hospitalized for 30 years, and a 55-year-old woman, also with chronic simple schizophrenia, who had been in the hospital for 40 years without having received any recent drug therapy.

Procedures. All 50 randomly selected patients received a complete physical and neurologic ex-

* Thiothixene (Navane) supplied by J. B. Roerig and Company, Division, Chas. Pfizer & Co., Inc.

TABLE 1.—*Acute schizophrenic patients.*

PT.	AGE	SEX	SUBTYPE	TIME IN HOSPITAL (BEFORE DRUG)	OPTIMAL DAILY DOSE
1	41	M	Undiff.	6 months	45 mg.
2	22	M	Undiff.	18 months	20 mg.
3	17	M	Paranoid	2 months	60 mg.
4	39	M	Simple	4 months	40 mg.
5	27	M	Undiff.	2 months	40 mg.
6	39	F	Undiff.	24 days	30 mg.
7	47	F	Paranoid	4 months	20 mg.
8	46	F	Paranoid	2 months	15 mg.
9	13	F	Paranoid	12 months	30 mg.
10	16	F	Childhood	5 years	15 mg.

TABLE 2.—*Chronic schizophrenic patients.*

PT.	AGE	SEX	SUBTYPE	TIME IN HOSPITAL (BEFORE DRUG)	OPTIMAL DAILY DOSE
11	42	M	Cat.	26 years	20 mg.
12	39	M	Undiff.		60 mg.
13	25	M	Paranoid	3 days	40 mg.
14	44	M	Cat.	8 years	30 mg.
15	53	M	Simple	30 years	20 mg.
16	31	M	Cat.	11 years	40 mg.
17	33	M	Paranoid	3 months	20 mg.
18	22	M	Paranoid	26 months	30 mg.
19	30	M	Undiff.	5 years	20 mg.
20	36	M	Paranoid	2 years	10 mg.
21	53	M	Paranoid	35 years	15 mg.
22	31	M	Undiff.	10 years	30 mg.
23	48	M	Cat.	20 years	20 mg.
24	45	M	Paranoid	4 months	15 mg.
25	27	M	Paranoid	12 months	40 mg.
26	52	M	Cat.	20 years	20 mg.
27	38	M	Paranoid	10 years	20 mg.
28	55	M	Heb.	35 years	30 mg.
29	37	M	Paranoid	14 years	30 mg.
30	37	M	Paranoid	17 years	15 mg.
31	40	M	Undiff.	18 years	15 mg.
32	41	M	Paranoid	9 years	60 mg.
33	42	M	Cat.	19 years	20 mg.
34	33	M	Paranoid	3 years	30 mg.
35	39	M	Cat.	22 years	20 mg.
36	50	M	Cat.	6 years	40 mg.
37	26	F	Paranoid	4 days	10 mg.
38	51	F	Simple	35 years	20 mg.
39	56	F	Cat.	18 months	30 mg.
40	32	F	Paranoid	7½ years	30 mg.
41	45	F	Heb.	15 years	10 mg.
42	24	F	Affect.	7 years	15 mg.
43	31	F	Paranoid	3 years	15 mg.
44	55	F	Simple	40 years	10 mg.
45	38	F	Paranoid	7 years	20 mg.
46	31	F	Affect.	7 years	60 mg.
47	45	F	Paranoid	15 years	30 mg.
48	26	F	Undiff.	3 years	30 mg.
49	50	F	Heb.	26 years	60 mg.
50	25	F	Paranoid	6 years	60 mg.

amination. Then an extensive psychiatric workup was done of each patient. Laboratory studies were performed before and after the study; these included white blood cell counts, hematocrit, hemoglobin, urinalysis, and liver function tests. Chest X-ray was done as a routine. WBC, differential count, and SGOT were repeated weekly and some cases EEG's were performed when necessary. Because of the random selection of these patients, no uniform drug-free period was instituted. Some patients were drug-free for as little as two days.

Psychiatric assessment during the study was made by the psychiatric staff and depended on daily observations and weekly interviews as well as on 24-hour observations made by the nurses and aides. A global psychiatric rating of improvement was made using five possible evaluations: marked, moderate, and slight improvements, unchanged, and made worse by treatment.

The initial daily dosage of thiothixene was 10 mg (5 mg b.i.d.). After 10 days, or at most 14, this dosage was gradually increased according to the individual patient's needs and reactions. The maximum daily dosage used in the trial was 60 mg of thiothixene (15 mg q.i.d. or 20 mg t.i.d.). No other medication was permitted for patients in the study other than an antiparkinsonian agent, mesylate (Cogentin), for control of extrapyramidal and other side reactions. No short-term drug treatment for a physical illness was required. The patients received milieu therapy during the observation period, but no electroshock or other somatic

TABLE 3.—*Clinical evaluation (global rating) of 50 schizophrenic patients.*

DEGREE OF IMPROVEMENT	CHRONIC SCHIZOPHRENICS	ACUTE SCHIZOPHRENICS	ALL PATIENTS
Marked	12	3	15
Moderate	14	6	20
Slight	6	0	6
Unchanged	7	1	8
Worse	1	0	1
TOTAL	40	10	50

TABLE 4.—*Side effects in acute schizophrenic patients [N=10].*

SIDE EFFECT	INCIDENCE
Agitation	1
Insomnia	1
Lethargy	1
Parkinsonism	4
Restlessness	3
Stiffness	1

Number of patients with side effects: 8
Number discontinued because of side effects: 2

treatment was undertaken at any point during the study.

RESULTS

The observation periods ranged from the 21 day minimum to 377 days. At the conclusion of the study, the average observation period for all 50 patients proved to be 201.2 days, for the chronic group, 202.85 days, and for the acute group 194.7 days. Table 1 (acute patients) and Table 2 (chronic patients) show the daily optimum drug dosage during the treatment period. The average daily dosage was 31.5 mg daily (15 to 60 mg daily); for the chronic group, 31 mg (10 to 60 mg daily); for the chronic group, 31 mg (10 to 60 mg daily).

Clinical evaluation at the end of the study strongly supported previous reports of the effective antipsychotic action of thiothixene at a level of safety comparable to that of other available psychotherapeutic drugs.

The effectiveness of thiothixene as a successor drug to the phenothiazines, which had failed to achieve any improvement in these patients, could usually be observed within a week to 10 days. Patients quickly became much more communicative and cooperative, less agitated, and far more easily manageable. As shown in Table 3, 15 patients (30%) showed a marked improvement, 20 patients (40%) were moderately improved, six patients (12%) were slightly improved, eight patients (16%) remained unchanged, and one patient (2%) became worse. At the conclusion of the study, 14 patients (28%) could be discharged from the hospital. Eighteen patients discontinued the drug, four for lack of response and 14 because of side effects (Tables 4 and 5).

Acute Group. Thiothixene proved especially effective in the ten acute schizophrenic patients. Nine demonstrated moderate (6) or marked (3) improvement. Two of the patients with marked improvement and two with moderate improvement were discharged from the hospital after 150 to 147 (one year is not acute) treatment days. Only one patient failed to respond to treatment; thiothixene was discontinued in two patients with moderate improvement (Table 1). Six side effects (Table 3) were observed, including four instances of parkinsonism; but treatment did not have to be stopped, since medication controlled the untoward side reaction. In the two patients who stopped taking the drug, withdrawal was made necessary by sleep difficulties and because of excessive and restlessness (Table 3).

Chronic Group. Encouraging results were also noted in the chronic group where marked improvement was observed in 12 patients, and moderate improvement in six patients. Seven patients remained unchanged, one became worse. There were 10 patients who were discharged in this group after 36 to 377 treatment days (Table 4). About half of this group demonstrated some sort of side effect (Table 5). Four instances of parkinsonism and four instances of akathisia were the most prominent; others were gastrointestinal disturb-

TABLE 5.—*Side effects in chronic schizophrenic patients [N=40].*

SIDE EFFECT	INCIDENCE
Agitation	1
Akasthesia	4
Dyskinesia	1
G.I. Distress	1
Leg Cramp	1
Parkinsonism	5
Restlessness	5
Stiff Neck	1
Stiffness	1
Stupor	1

Number of patients with side effects: 20
Number discontinued because of side effects: 12

ances, leg cramps, restlessness, stupor, agitation, and stiff neck. Despite the 21 side effects, thiothixene was discontinued in only 12 patients because of a side effect; four patients stopped the drug for lack of response (Table 5).

With one exception, no EKG abnormality was observed in the 50 patients. Thiothixene did not appear to cause any significant laboratory abnormalities. Some blood counts and chemistries were generally at upper limits of normal levels, but these could not be linked to the drug, and also were not significantly elevated from baseline levels.

DISCUSSION

In schizophrenic patients who had failed to respond to previous medication, thiothixene demonstrated definite antipsychotic activity. Acute schizophrenic patients appeared to respond especially well, while the response observed among chronic schizophrenic patients was also most encouraging (Table 3).

The major problem that remains is the question of dosage, and in this matter the available literature is of little help. Hekimian *et al*[4] used up to 120 mg of thiothixene (this is double the maximum recommended dosage), while Pennington[7] used only up to 25 mg daily in both acute and chronic schizophrenic patients. It seems that dosages need to be determined empirically (and the best method is to start on 10 mg daily for the first week or 10 days). The dosage is then slowly increased. As the higher doses are given, side effects will begin to appear. But hyperexcitation may be a good sign that the drug is working. Most untoward side effects appeared to occur after the second month of treatment.

This study did not confirm the contention of Hekimian and associates[4] that higher improvement ratings correlated with higher dosages. Marked and moderate improvements were noticed on as little as 15 mg of thiothixene daily. There seemed to be no correlation between dosage, side effects, and improvement. A 53-year-old man who had been hospitalized without treatment for 30 years showed marked improvement on 20 mg of thiothixene daily and was actually discharged after 377 days of treatment (the longest in this series). By contrast, the 55-year-old woman who had been hospitalized for 40 years without medication failed to respond to 10 mg daily.

In analyzing the dosage schedule, it was noted that there seemed to be a marked difference between the chronic and acute schizophrenic patients, and a sex-determined difference within the two groups. Thus, the average dosage of thiothixene was 28.5 mg daily for all patients. The 10 acute patients received an average of 31.5 mg daily. However, the men received almost twice as much as the women in this group. The five acute schizophrenic women received an average of 22 mg daily (ranging from 15 to 30 mg), while the five men received 41 mg as an average daily dosage (from 40 to 60 mg). This might suggest that acute male schizophrenic patients *may* require larger dosages. However, the sample is too small for such a conclusion.

When the dosage schedule for the chronic patients was analyzed, it revealed that the 14 women required larger optimum dosages, on the average 38.57 mg daily, while the 26 men required only 27.3 mg. These intriguing findings suggest further studies in the individual requirements of a specific group of patients.

That such encouraging results could be achieved on relatively medium-sized dosages, and that treatment could be continued for a number of patients despite untoward side effects, leads to an inevitable conclusion: Thiothixene works very well in schizophrenia, and should definitely be a first choice, or used when one of the better-known antipsychotics does not work or is not tolerated.

Hawaii State Hospital, Kaneohe, Hawaii 96744.

REFERENCES

1. Hollister LE: Clinical use of psychotherapeutic drugs: Current status. *Clin Pharmacol Ther* 10:170, 1969.
2. Angus JWS, Iqbal F, Iqbal J and Simpson GM: A year's trial of thiothixene in chronic schizophrenia. *Int J Neuropsychiat* 3:408, 1967.
3. Bishop MP, Gallant DM, and Steele CA: Extended trial of Thiothixene in chronic psychotic patients. *Psych Digest* 29:15, 1968.
4. Hekimian LJ, Gershon S, and Floyd A, Jr: Some clinical and physiologic effects of a thioxanthene derivative, thiothixene (P-4657B), in 20 newly hospitalized male schizophrenics. *J Clin Pharmacol* 7:52, 1967.
5. Kurland AA, Pinto A, Dim BH, and Johnson CA: Pilot study of Navane (thiothixene) in chronic schizophrenics and acute psychotic patients. *Curr Ther Res* 9:298, 1967.
6. Overall JE, Hollister LE, Shelton J, Kimbell I, and Pennington V: Broad-spectrum screening of psychotherapeutic drugs: Thiothixene as an antipsychotic and antidepressant. *Clin Pharmacol Ther* 10:36, 1969.
7. Pennington VM: The antipsychotic and antidepressant power of Thiothixene. Psychosomatics 9:346, 1968.



CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 312, Camden, New Jersey 08101.

There's a soup for almost every patient and diet ...for every meal and, it's made by Campbell

Hawaii Life Table Values by Causes of Death: 1959-61

Mostly, you live longer in Hawaii, and here is the detailed proof of it.

CHAI BIN PARK, M.D., and Y. SCOTT MATSUMOTO, Ph.D.

Abridged life tables of specified causes of death and those eliminating causes were constructed for the population of Hawaii for 1959-61 by color and sex.

Generally, the probabilities of eventually dying from a specified cause are higher for non-whites. Only in cardiovascular-renal (CVR) disease is it higher for the white, principally because of the difference in arteriosclerotic heart disease. However, hypertensive heart disease presents a distinctly higher risk for the non-white. Men generally show higher probability, but again the reverse is observed for CVR diseases, especially for arteriosclerotic heart disease in the white. The color difference in general is marked in men, with the difference relatively small for women.

On the average, women die later than men except for communicable diseases in both color groups, and for pneumonia and influenza in non-whites. The average ages of death of non-whites are usually higher than those of whites except for communicable diseases and cerebrovascular lesions in women.

Elimination of a specified cause generally results in a longer extension of life in non-whites than in whites. (In cancer it is so only for men.) However, in arteriosclerotic heart disease the elimination prolongs life more in whites, especially in men, than in non-whites. Essentially because of this differential in arteriosclerotic heart disease, the gains of white life expectation are still greater than those of non-white even when total heart diseases or all CVR diseases are eliminated. The sex differential varies by cause. In hypertensive heart disease and cerebrovascular lesions of both color and in cancer of the whites, the gains of women are greater than men. However, in arteriosclerotic heart disease, infectious diseases, accidents, and digestive organ cancers in both color groups and in all cancers and pneumonia in non-whites, the opposite is true. Riddance of over-all heart disease shows a longer life extension for women in non-whites, and for men in whites. For all CVR diseases, the woman gains more.

Contrasted to other causes, hypertensive heart disease conspicuously presents a higher probability of dying for Hawaiian residents than for all U.S. The probability is also higher in the cancers of digestive organs, not only for non-white men, but also for white men in Hawaii, than for the comparable U.S. group. Within a given cause, deaths tend to occur later in life in Hawaii than in the whole U.S. However, in hypertensive heart disease the Island whites die earlier than the mainland U.S. whites, and in cancers of digestic organs, the Island white women do likewise.

THE FIRST official life tables by causes of death for the U.S., published in 1968, were based on the mortality experience of 1959-61.[1] For each state, including Hawaii, life tables combining all

The authors are from the School of Public Health, University of Hawaii, and East-West Population Institute, East-West Center, Honolulu.

Received for publication July 17, 1970.

causes of death are available in a series of publication by the National Center for Health Statistics.[2] However, tables by causes of death for each individual state were not constructed. In this paper, therefore, certain life table values of Hawaii are presented in which deaths are divided into components according to specified causes of death.

MATERIAL AND METHOD

This report is based on the State of Hawaii life tables and the deaths in Hawaii by cause, color, sex, and age for the three-year period, 1959-61.[3] It is realized that the "non-white" group is a very heterogeneous mix in Hawaii. Unfortunately, because of the nature of the material used, the classifications of the population are made in terms of color (white or non-white) rather than by ethnic groupings.

The causes of death listed in Table 1 were selected for the present study. In the 11 groups of causes listed, only six are mutually exclusive. The remainder are subgroups of major cardiovascular-renal (CVR) diseases and malignant neoplasms. Eighty-two percent of all deaths during this period were due to these causes. The classification of causes was in accordance with the 1955 revision of the International Classification of Diseases, Injuries and Causes of Death (ICD).

For each of the causes listed in Table 1 the probabilities of eventually dying of it, and average ages of death, are analyzed. From abridged life tables eliminating a specific cause, life expectancies at selected ages are discussed, omitting other life table values. (Life tables of conventional form may be obtained upon request from the senior author.) For infective and parasitic diseases, interpretations should be made with caution because of the small number involved, especially in the subgroups of population.

As to the technical methodology, one is referred to the national tables[1] or standard textbooks, such as Spiegelman's.[4] In the construction of the national tables eliminating a specified cause of death, an approximate formula was used for the computation of the probability of dying for a given age interval, but in the present paper an exact formula was used. On the other hand, in the national tables the number of persons living in the stationary population in a given age group under age 85 was obtained by summing up the estimated stationary population for each individual age, but here an approximation was calculated for all age groups.

PROBABILITY OF EVENTUALLY DYING

Table 2 gives the probabilities, at four selected ages, of eventually dying from specified causes. Out of every 100 born alive, more than half will ultimately die from CVR diseases in Hawaii. The lowest risk group is the non-white men, and the highest the white women. The probability of whites is higher than that of non-whites; likewise women than men. The color difference in men is large, but that in women small. As to be expected, the probability increases with age.

Deaths due to heart diseases and cerebrovascular accidents comprises 90 percent of all CVR deaths. Arteriosclerotic and hypertensive heart diseases, in turn, constitute 85 percent of all heart disease deaths. The probabilities at birth of eventually dying from heart diseases are about 0.4%. The white shows definitely higher risk than the non-white. The sex difference is not uniform by color. In whites women present a trace of lower probability than men, but in non-whites women are somewhat higher than men. With age the probability gradually ascends for all groups as in the total CVR diseases.

TABLE 1.—*Major causes of death,* Hawaii, 1959-61.*

CAUSES OF DEATH	NO. OF DEATHS	PERCENT OF TOTAL DEATHS
1. Infective and parasitic diseases (001-138)	130	1.3
2. Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues (140-205)	1,756	17.0
2.1 Malignant neoplasms of digestive organs and peritoneum, not specified as secondary (150-156A, 157-159)	770	7.5
3. Major cardiovascular-renal diseases (330-334, 400-468, 592-594)	4,664	45.2
3.1 Vascular lesions affecting central nervous system (330-334)	942	9.1
3.2 Diseases of heart (400-402, 410-443)	3,262	31.6
3.2.1 Arteriosclerotic heart disease, including coronary disease (420)	2,049	19.9
3.2.2. Hypertensive heart disease (440-443)	742	7.2
4. Influenza and pneumonia except pneumonia of newborn (480-493)	396	3.8
5. Certain diseases of early infancy (760-776)	808	7.8
6. All accidents (E800-E962)	704	6.8

* Numbers in parenthesis are the code numbers in the 1955 Revision of the International Classification of Diseases (ICD).

TABLE 2.—*Probability of eventually dying from specified causes of death: Hawaii, 1959-61.*

EXACT AGE	CAUSE OF DEATH*										
	1	2	2.1	3	3.1	3.2	3.2.1	3.2.2	4	5	6
TOTAL POPULATION											
0	0.012	0.168	0.080	0.567	0.116	0.396	0.250	0.086	0.046	0.016	0.040
20	.012	.172	.083	.586	.120	.408	.258	.089	.044		.037
40	.011	.173	.084	.595	.122	.416	.263	.091	.045		.030
60	.011	.161	.081	.614	.128	.428	.270	.092	.050		.025
WHITE MEN											
0	0.009	0.162	0.063	0.574	0.086	0.445	0.346	0.051	0.034	0.016	0.052
20	.009	.167	.065	.594	.089	.460	.358	.053	.033		.047
40	.010	.170	.066	.603	.090	.468	.364	.054	.034		.036
60	.009	.163	.065	.626	.096	.481	.371	.055	.037		.029
WHITE WOMEN											
0	0.005	0.148	0.052	0.630	0.142	0.438	0.270	0.086	0.034	0.013	0.025
20	.005	.151	.054	.646	.146	.449	.278	.089	.033		.023
40	.005	.150	.054	.654	.147	.455	.282	.090	.033		.021
60	.004	.125	.047	.693	.163	.474	.301	.088	.034		.018
NON-WHITE MEN											
0	0.016	0.188	0.101	0.514	0.105	0.359	0.223	0.084	0.054	0.018	0.053
20	.017	.194	.105	.534	.109	.372	.232	.087	.053		.049
40	.017	.196	.106	.544	.111	.380	.237	.090	.054		.039
60	.018	.190	.104	.556	.115	.387	.240	.090	.060		.032
NON-WHITE WOMEN											
0	0.006	0.142	0.067	0.622	0.142	0.409	0.224	0.114	0.039	0.014	0.022
20	.006	.145	.069	.639	.146	.421	.230	.118	.038		.020
40	.005	.144	.069	.646	.148	.426	.234	.119	.038		.018
60	.004	.127	.067	.666	.151	.443	.247	.121	.040		.016

* See Table 1 for identification of the group.

The probabilities of dying from arteriosclerotic and hypertensive heart diseases present wide differences depending on color and sex. In arteriosclerotic heart disease the probability of death in whites is distinctly higher than that in non-whites, but in hypertensive disease the probability in non-whites is higher. In the former, the white man is definitely the more vulnerable sex, but there is no particular sex differential in the non-white. On the other hand, in the latter heart disease, the woman uniformly presents much higher risk in both color. In both heart diseases, the difference between the white and non-white men varies widely.

The overall probability at birth of eventually dying from cerebral hemorrhage is about 0.12%. The lowest risk group is the white male, the probability being below 0.1% even at age 60. The non-white man presents somewhat higher probability than the white man. Women are distinctly more vulnerable than men. Little difference is noted between white and non-white women.

In the total population of Hawaii, the probability at birth of ultimate death from all cancers is about 0.17%. It rises slowly with age, reaching a plateau at age 30-40, then starts to decline, reaching about 0.1% at age 80. The man is the higher-risk sex group, and among men, the non-whites show a higher probability. However, there is little difference by color among women. Primary cancers of digestive organs present a higher risk of eventual death in non-whites than in whites. Among all groups, the non-white man shows conspicuously higher risk, probably reflecting the high incidence of stomach cancer among Japanese men[5] who composes approximately half of the non-white group.

The risk of ultimate death from communicable diseases is small in all groups. It remains almost constant between birth and age 40 and then gradually decreases. The risk is distinctly higher for men in both color groups, especially in non-whites, where the difference is nearly three-fold. Though whites exhibit lower probabilities, the color difference is small among women.

The probability of eventually dying from influenza or pneumonia, dropping after the first year of life, remains unchanged up to age 30 and then gradually rises. The risk of whites is lower than that of non-whites, especially in men. There is little sex difference within the white groups, but among non-whites the man shows definitely higher risk.

Diseases of early infancy present slightly higher probability of dying for non-whites than for whites. In both color groups, the risk is higher for boys.

The chance of eventually dying from accidents

TABLE 3.—*Life table—mean and median ages of death by cause, color and sex: Hawaii, 1959-61.*

CAUSE OF DEATH*	MEAN AGE OF DEATH					MEDIAN AGE OF DEATH				
	Total Population	WHITE		NON-WHITE		Total Population	WHITE		NON-WHITE	
		Men	Women	Men	Women		Men	Women	Men	Women
1.	68.81	67.93	64.53	71.08	57.22	72.34	69.54	67.30	73.68	63.12
2.	69.92	67.72	67.33	70.61	70.38	71.98	67.86	68.56	72.87	73.06
2.1	71.89	68.78	68.97	72.16	73.13	73.58	68.83	70.76	73.93	75.64
3.	75.71	70.69	76.56	75.20	78.61	77.83	71.73	78.22	77.36	81.18
3.1	75.85	72.46	78.90	74.44	77.56	77.70	73.98	81.18	76.03	79.22
3.2	75.68	70.07	75.99	75.49	79.03	77.79	70.94	77.35	77.81	81.56
3.2.1	75.64	69.48	76.78	75.60	79.90	77.46	69.93	77.90	77.86	81.66
3.2.2	74.35	71.19	72.02	73.82	77.44	76.11	73.19	73.79	74.65	79.91
4.	76.82	69.82	74.86	78.16	77.36	82.54	73.68	81.13	83.68	83.26
6.	56.16	50.85	60.59	54.84	62.49	60.62	54.15	65.10	58.54	69.55

* See Table 1 for identification of the group.

increases slightly after the first year of life and then slowly decreases for the remainder of life. As might be expected, the lifetime risk for men is distinctly higher than for women, being over two-fold. Among men, the probability at birth differs little by color, but in later life the risk for non-whites becomes slightly higher. Among women, the non-whites appear to show a slightly lower probability.

AVERAGE AGE OF DEATH

Both arithmetic mean and median ages of "life table deaths" are presented in Table 3 by causes of death. Contrasted to the observed averages, those from "life table deaths" are computed for the stationary population derived from the general mortality experience and are free from the effect of the age distribution of the actual population.

As seen from the table, the median is always higher than the corresponding mean, due to the skewed distribution of deaths to younger ages. The lowest average age is observed in accident deaths. Infectious diseases place next lowest among the means. However, in terms of median, cancer mortality has a slightly lower average than that for infectious diseases because of the difference in the mortality in early life. The average ages of deaths due to CVR diseases are well over 70. The highest average is for deaths of influenza and pneumonia, the large number of deaths at very old ages offsetting the moderate number in early childhood.

In general, the average age of death is lower for men than for women. However, in infectious diseases the situation is reversed, regardless of color or type of average. Also, a non-white man is likely to die slightly later from influenza and pneumonia than a non-white woman. Little sex difference is observed with cancer deaths. Hypertensive heart disease presents a small sex difference in whites. Very large sex variations are observed in the deaths from accidents and for non-white deaths from infectious diseases.

The non-white generally possesses several years higher average ages of death than white for both sexes. However, in deaths due to infectious diseases and cerebrovascular accidents, an average white woman dies later than a non-white woman. In hypertensive heart disease deaths, the average age for non-white men is only slightly higher than that for the white man. A difference of a decade is observed between white and non-white men in influenza and pneumonia deaths.

GAIN IN EXPECTATION OF LIFE

From the public health viewpoint, the most important life table value is the expectation of life, especially that at birth. The gains in expectation of life that could be attained if a specified cause of death were eliminated are shown in Table 4 at four different ages, each 20 years apart.

The life expectancy at birth in the total population when all causes of death are combined is 71.55 years. By eliminating all CVR diseases, more than eight years of life expectancy would be added at birth. The gain would increase slightly to form a plateau at age five to 30 years, and then gradually decrease. In relative terms, the gain would steadily increase from 12% at birth to 24% at age 40, and to as much as 60% at age 75.

The gain of the white exceeds that of the non-white, with women over men. The color differential is larger in men than in women, and sex differential larger in non-whites than in whites. In white men the relative gain corresponds to about 14% at birth to nearly 80% at age 75. Similar relative gain is observed for white women, but the magnitude is somewhat smaller. In non-white men the relative extension of life expectancy is 10% at birth and reaches over 50% at age 75. The trend

TABLE 4.—*Gain in expectation of life due to elimination of specified causes of death: Hawaii, 1959-61.*

EXACT AGE	LIFE EXPECTANCY WHEN ALL CAUSES COMBINED	GAIN IN LIFE EXPECTANCY BY ELIMINATING CAUSE OF DEATH*									
		1	2	2.1	3	3.1	3.2	3.2.1	3.2.2	4	6
TOTAL POPULATION											
0	71.55	0.16	2.36	0.98	8.30	1.18	4.98	2.80	0.93	0.48	0.99
20	53.91	0.14	2.36	1.00	8.50	1.21	5.10	2.90	0.96	0.32	0.72
40	34.99	0.14	2.25	0.98	8.42	1.21	5.05	2.90	0.96	0.32	0.41
60	18.42	0.11	1.61	0.75	7.43	1.06	4.36	2.47	0.79	0.29	0.21
WHITE MEN											
0	66.95	0.12	2.04	0.70	9.28	0.83	6.33	4.57	0.51	0.41	1.29
20	49.19	0.09	2.04	0.72	9.55	0.85	6.51	4.73	0.53	0.29	0.94
40	30.27	0.10	2.01	0.72	9.49	0.85	6.47	4.70	0.52	0.30	0.47
60	14.50	0.06	1.52	0.56	8.29	0.74	5.48	3.89	0.42	0.25	0.24
WHITE WOMEN											
0	72.38	0.07	2.30	0.70	9.48	1.23	5.53	2.84	1.03	0.40	0.52
20	54.35	0.07	2.32	0.73	9.64	1.27	5.60	2.93	1.06	0.25	0.36
40	35.20	0.07	2.18	0.73	9.58	1.24	5.58	2.95	1.06	0.25	0.27
60	18.53	0.05	1.30	0.46	9.05	1.26	5.04	2.80	0.85	0.19	0.15
NON-WHITE MEN											
0	70.69	0.21	2.58	1.22	7.42	1.14	4.49	2.50	0.92	0.54	1.36
20	53.45	0.19	2.58	1.26	7.63	1.16	4.62	2.60	0.96	0.34	1.01
40	34.83	0.18	2.46	1.21	7.53	1.15	4.55	2.57	0.97	0.34	0.51
60	18.21	0.17	1.93	0.97	6.51	1.01	3.84	2.10	0.82	0.35	0.27
NON-WHITE WOMEN											
0	74.81	0.15	2.17	0.86	8.66	1.46	4.70	2.14	1.18	0.44	0.47
20	56.94	0.12	2.15	0.88	8.83	1.50	4.79	2.20	1.21	0.29	0.32
40	37.83	0.09	2.02	0.85	8.69	1.50	4.71	2.23	1.19	0.27	0.22
60	20.75	0.06	1.28	0.65	7.83	1.28	4.31	2.10	1.01	0.25	0.13

* See Table 1 for identification of the group.

of females is similar, but the magnitude is somewhat larger.

Approximately five years would be gained in the expectation of life at birth if heart diseases were eliminated. Though the gain by whites exceeds that of non-whites, as before, the sex differentials are not consistent by color. The white man gains more than the woman, but the reverse is true for non-whites.

The elimination of arteriosclerotic heart disease would result in a greater prolonging of life among whites than non-whites, and more among men than women. The sex differential is much greater in the white than in the non-white. The color difference in men is remarkable; the white would gain two years more than the non-white at birth. If hypertensive heart disease were eliminated, the non-white would prolong life longer than the white, and the women more than the men. For the whites, the women's gain is twice that of men.

By eliminating cerebral hemorrhage, non-whites would add more years in life than whites, and women more than men. The white man would gain the least among the four population groups, adding only 0.8 years at birth. On the other hand, the non-white woman, adding almost 1.5 years, would gain the most.

The addition in the life expectancy would briefly increase after infancy if all malignant neoplasms were disposed. From age five, the years added would slowly decrease. These gains correspond to a steady relative increase with age, but in old ages even the relative increase begins to decline. The prolonging of life would be greater for women in whites, but the opposite is true in non-whites. The gain of white men is less than that of non-white men. The relative gain at birth is not very large; in all groups it is about three percent. The maximum relative increase varies from group to group, both in age and the magnitude it attains. While the largest relative increase is attained in the seventh decade of life in non-whites, it is fully 10 years earlier in whites. In man the maximum gain of life expectancy is over 10%; but in women, 7% or less.

The addition of life expectation by the elimination of primary cancers of digestive organs would present a very slow but steady increase up to the age of about 30 and then tails off. The relative gain would gradually increase until age 70. The non-white would gain more than the white. Little man-woman difference is observed in whites until old age. In non-whites the gain of the man is distinctly more than that of the woman.

If infectious diseases were eliminated, the extension of the mean life of the non-white would be about twice that of the white. The gain of men would be more than that of women. The absolute

magnitude of the life years added slowly decreases with age, but the relative magnitude appears to rise slowly after an initial brief decrease.

Influenza and pneumonia as causes of death shorten about one-half year of life expectancy at birth. The effect of this cause is somewhat larger in non-whites than in whites. At birth there is little sex difference in whites, but in later adult life the loss of future life is greater in men. In non-whites the man's loss of future life is consistently larger.

As might be expected, the elimination of accidents would prolong man's life more than the woman's. In either color group the gains of men are more than twice those of women at birth and in the young ages. The color difference is not consistent. In men there is longer extension for non-whites, but in women the reverse is observed. The relative amount of life addition differs by sex. In men during the first two and a half decades of life, the increase of future life is invariant, being about 2%. Then it drops to about 1.5% and remains there until old age. In women the percentage gain shows a decrease, though very slow, from birth to the 30's; then it starts to rise.

In addition to the causes given in Table 4, the elimination of diseases of early infancy would result in prolonging the white lives by 1.06 years for men and 0.97 years for women; and for non-white, 1.31 and 1.03 years respectively.

DISCUSSION

Based on mortality data, attempts have been made to determine quantitatively the priorities of health problems. *Magnitude* and *importance* of the cause of death have been often-used criteria in such presentations.[6, 7] The *magnitude* of a cause is measured by the ratio of deaths from the specific cause to total deaths. The measurement of the *importance* of a cause has been approached by obtaining a weighted mean age of deaths from the cause, usually giving arbitrarily larger weights to the younger ages.

These measures are, like the crude death rate, influenced by the age composition of the population. By using the life table values this influence may be overcome. While the probability of eventually dying from a cause is dependent upon the amount of deaths to occur, the gain of life expectancy by eliminating a cause is determined both by the amount of the deaths and the ages when the deaths occur. Therefore, a single measurement of the gain in life expectancy may serve as an index in determining the health problem priorities. The ranking of causes for the present data based on this criterion generally agrees with that based on the overall percentage distribution by cause. This indicates that in the mortality experience in Hawaii, the magnitude of deaths is crucial regardless of the ages where they occur.

Bennett *et al*[8] suggested an association of hypertension and cerebrovascular disease in Hawaii, observing that mortality of these diseases was higher than on the mainland but that of arteriosclerotic heart disease was lower in Hawaii. However, the present data do not fully agree with this observation. In hypertensive heart disease Islanders present uniformly higher probabilities of dying than the comparable U.S. groups, but in cerebrovascular lesions the contrary is true (Table 5). In the

TABLE 5.—*Probability at birth of eventually dying from selected cause of death, by color and sex, U.S. and Hawaii: 1959-61.*

	PROBABILITY OF EVENTUALLY DYING FROM:						
	MALIG. NEOPLASMS	MALIG. NEOPLASMS OF DIG. ORG.	CVR DISEASES	CEREBRO. LESIONS	HEART DISEASES	ART. HEART DISEASE	HYPERT. HEART DISEASE
White Men							
U.S.	.152	.054	.594	.107	.438	.352	.029
HAWAII	.162	.063	.574	.086	.445	.346	.051
White Women							
U.S.	.154	.057	.645	.159	.424	.297	.052
HAWAII	.148	.052	.630	.142	.438	.270	.086
Non-White Men							
U.S.	.131	.051	.521	.126	.337	.202	.069
HAWAII	.188	.101	.514	.105	.359	.223	.084
Non-White Women							
U.S.	.124	.041	.612	.175	.371	.196	.100
HAWAII	.142	.067	.622	.142	.409	.224	.114

Source of U.S. Data: Public Health Service "United States Life Table by Causes of Death: 1959-61," *Life Tables: 1959-61*, Vol. 1—No. 6, PHS Pub. No. 1252, May, 1968.

TABLE 6.—*Gain in life expectancy at birth eliminating selected causes of death, by color and sex, U.S. and Hawaii: 1959-61.*

	GAIN IN YEARS IN LIFE EXPECTANCY ELIMINATING:						
	MALIG. NEOPLASMS	MALIG. NEOPLASMS OF DIG. ORG.	CVR DISEASES	CEREBRO. LESIONS	HEART DISEASES	ART. HEART DISEASE	HYPERT. HEART DISEASE
White Men							
U.S.	2.12	.63	10.85	.99	6.51	4.88	.27
HAWAII	2.04	.70	9.28	.83	6.33	4.57	.51
White Women							
U.S.	2.43	.68	10.47	1.43	5.04	3.13	.45
HAWAII	2.30	.70	9.48	1.23	5.53	2.84	1.03
Non-White Men							
U.S.	1.98	.70	10.44	1.60	5.40	2.82	.90
HAWAII	2.58	1.22	7.42	1.14	4.49	2.50	.92
Non-White Women							
U.S.	2.18	.59	12.53	2.34	5.78	2.54	1.35
HAWAII	2.17	.86	8.66	1.46	4.70	2.14	1.18

Source of U.S. Data: Public Health Service "United States Life Table by Causes of Death: 1959-61," *Life Tables: 1959-61,* Vol. 1—No. 6, PHS Pub. No. 1252, May, 1968.

arteriosclerotic heart disease the Island whites show slightly lower probabilities, but the Island non-whites are the reverse. The discrepancy from the findings of Bennett *et al* may be partly due to the age limitation of deaths. Their data were limited to deaths at ages 35 through 74 years. Many of the CVR deaths occur after age 75, and there appears to be a large difference in the age distribution of deaths between the mainland and Hawaii. For instance, the gain of life expectancy eliminating all CVR diseases is noticeably small for Hawaii non-whites (Table 6), in spite of the fact that the probability of dying from CVR is only slightly lower (men) or even higher (women) for the Islanders.

Because of the nature of the measurements, the ratio of the probability of ultimately dying from a cause to the gain of life expectancy eliminating the cause will provide an index of age distribution of the death; the higher the ratio, the younger the age distribution of the deaths. From such ratios, it is apparent that the Hawaiian non-whites die much later from various CVR diseases than the corresponding non-white U.S. groups. Among the whites there are no appreciable differences for the causes of arteriosclerotic heart disease and cerebrovascular lesions. However, for hypertensive heart disease the Hawaiian white appears to die earlier, especially in women, than the U.S. white.

In cancer, Hawaiian white women appear different from the other Island groups, being the only group to present lower probabilities of dying than the comparable group of the U.S. Because of the Japanese man, it is natural to observe a high probability of dying from digestive organ cancers for the non-white man in Hawaii. However, it is of interest to note that even the white shows a higher probability in men in comparison with the total nation. Apparently the white woman deaths from the cancers of digestive organs in Hawaii occur earlier than those in the U.S. It has been consistently observed that the Caucasian women in Hawaii have higher incidence of cancer of large intestine than any other group.[9, 10] Further investigation is needed to study whether or not there is any significant difference in the age distribution of patients or deaths of cancers of this particular site between Hawaii and the Mainland.

ACKNOWLEDGMENT

The computation was performed by courtesy of University of Hawaii Statistical and Computing Center facilities. Grateful acknowledgment is due to Mr. Edward Yonemoto for his assistance in programming.

REFERENCES

1. U.S. Public Health Service. "United States life tables by causes of death: 1959-61," *Life Tables: 1959-61,* Vol. 1—No. 6, PHS Pub. No. 1252. 1968.
2. U.S. Public Health Service. "State life tables: 1959-61," *Life Tables: 1959-61,* Vol. 2, PHS Pub. No. 1252, 1966.
3. U.S. Public Health Service. *Vital statistics of the United States, 1959, 1960 and 1961,* Washington: 1961, 1962, and 1963.
4. Spiegelman M: *Introduction to demography,* revised ed. Harvard Univ. Press, 1968, Cambridge.
5. Hawaii Cancer Commission. *Cancer in Hawaii 1960,* Mimeographed, 1962, Honolulu.
6. Pan American Health Org. *Health planning: problems of concept and method,* PAHO Sc. Pub. No. 111, 1965, Washington, D.C.
7. U.S. Public Health Service. *The principles of program packaging in the Division of Indian Health,* 1966, Silver Spring, Md.
8. Bennett CG, Tokuyama GH, McBride TC: Cardiovascu'ar renal mortality in Hawaii. *Amer J Public Health* 52:1418-1431, 1962.
9. Quisenberry WB: Gastro-intestinal cancer in Hawaii. *Acta Union Internationale Contre Le Cancer* 17:324-329, 1961.
10. Hawaii Tumor Registry. Cancer in Hawaii: morbidity and treatment—five years 1960-1964. HAWAII MED. J. 27:409-456, 1968.

The President's Page



By the time you read this our annual meeting will be over and my term as your President finished. In three days during mid-April as your representative I spent over ten hours in meetings of the Health and Community Services Counеil, Comprehensive Health Planning and R.M.P. The relationship of the last two is fuzzy but you eаn be sure as increasing governmеnt dollars are used to pay for health eosts, consumer groups will have more to say about how these monies are spent. We as a profession can leave the planning to others, eagerly seeking to spend these funds according to their plans, or we can take a leadership role in formulating the plans. By training and praetice we should be able to contribute. It takes physicians time and involvement and it takes a professional staff to support the physician's efforts. This takes money, and your medieal assoeiation dues pay for this support.

Someone must speak for the majority opinion of the profession. If you want to influenee the future course of medieine, get active in determining the position your medieal association takes. If you do not agree with the leadership, ehange it; but do not drop out and then eriticize. The needs and abilities of our developing degree-granting medical sehool should be taken into account in our eommunity oriented efforts.

From the public's standpoint, medical expenses are high. They have esealated rapidly, partieularly beeause previously underpaid nurses and health professionals are getting deserved pay inereases, and partly beeause there are a great many new health professionals who are necessary to deliver the improved and inereased services.

Our government has deelared that medieal eare shall be available to all, regardless of ability to pay. You eannot provide more and better serviees at less eost. To me one of the ways we ean save the most tax money is to prevent our planners from providing serviees whieh the publie ehooses not to use. If for no other reason, this means we must preserve a pluralistic system, beeause no one system meets the needs of all. Businessmen, engineers, administrators and eeonomists are neeessary to make the health industry efficient, but I believe it will fail if it does not meet the personal needs of the patients it is designed to serve. When it eomes to patient eare and peer review, I doubt if the physician is expendable.

I hope our profession will present a cooperative attitude to all those we must work with to improve medical care. With young people the world over eoming to America for training, medieal eare in America eannot be the failure some would have us believe.

My sincerest thanks to the many unselfish physieians who have done the work of the Association this past year, to our devoted Woman's Auxiliary, and to our effieient and dedicated staff who have given me such wholehearted support!

Mahalo, and aloha!

John J Lowrey

Editorials

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii

The ninetieth installment of this remarkable series of short biographies of Hawaii physicians appears in this issue of the JOURNAL. We have had from two to four biographies in every issue since the series began in 1956—15 years in all.

The project, originally suggested by Mrs. J. Warren White, the widow of one of Hawaii's first and foremost orthopedists and the sister-in-law of Dr. Paul Dudley White, has been almost the sole responsibility of Mrs. Robert Y. Katsuki, though it has been sponsored from the start by the Woman's Auxiliary to the Hawaii Medical Association.

The sketches have been compiled from such sources as newspaper clippings, biographical data from *"Men of Hawaii," Who's Who,* and so on, and sometimes communication with family members. Old records in the Board of Health and the Archives of Hawaii have been studied for countless hours for information, much of it leading to rewriting of earlier sketches in the light of new information.

The first two volumes were presented to the Hawaii Medical Association in 1956, on the Association's 100th birthday. There are now four volumes, totalling over 900 pages, with 428 biographies, 263 with photographs, of doctors from the early 1800's to the present. Duplicate sets have been presented to each of the three neighbor island county medical societies. Negatives for the photographs are on file in the HMA office, and can be borrowed.

Only about three-fourths of the biographies have been published so far, and it is not intended to continue the published series forever: when we start to overlap already published obituaries, we will let the series come to a dignified conclusion. And since that day is not far off, we want here and now to express our warm appreciation to Betty Katsuki, whose labor of love has resulted in such a splendid historical documentation of the lives of the physician of Hawaii over this past century. We thank her, for all our members, from the bottom of our collective heart!

Inside HMA

HAWAII MEDICAL JOURNAL

Telling It Like It Is

. . . A bouquet to the **Woman's Auxiliary Committee,** which I raked over the coals some months back. Our committee is now working with the ladies on compiling biographical sketches of the doctors of Hawaii.

. . . **News Media,** with cooperation from **Public Relations** (State and County) spent long hard hours working on the new Code of Cooperation between the doctors, hospitals, and the news media, and a new publicity code for physicians. It should simplify and improve our relations with the media and help improve our public image.

. . . At the recent Legislature, **Environmental Health** put in some long hard work on many bills relating to our environment. Everyone is now an ecology expert and concerned about ecology which is fine except for the occasional tendency to run around banning things without realizing the value of adequate study. As you well know, the principal pollution bill did not pass, but undoubtedly will at the next Legislature. It will be a better bill because of the long hours put in by our committee.

. . . **Chronic Illness and Aging** has put in extra hours preparing for the current convention and working on the Senior Citizens' Center, including the monthly health day.

. . . **School Health** has been working closely with the DOE and the Department of Health on a school health pilot project at Baldwin High School on Maui, a sports medicine workshop, a new teacher's health certificate, an improved health education program on sex, drug abuse, etc. There is a new pilot training program project for Scoliosis. The Department of Health wants to do a pilot program examining clean catch urine specimens to rule out urinary tract infection in elementary school children. It also had two joint meetings with the **Communicable Disease and Immunization, Venereal Disease** and **Tuberculosis Committee** with special reference to the increasing problem of venereal disease in school children. All the doctors seem to agree that a better health education program should be developed. I think it is time we got together and did more to educate parents on the necessity of a better program to educate the children as to the causes, prevenion and cure of venereal disease in teenagers. A surprisingly few local parents, generally with little comprehension of the realities, can make the DOE problem very difficult. We should be speaking out more strongly on the fine things the DOE has been doing and on the necessity for even more and better sex education in the schools. The reality is that in the last five years the incidence of venereal disease in the high school age group has doubled.

. . . **Quackery** is concerned about a number of recent chiropractic advertisements and wants to develop a program to attempt to counter these and to more properly educate the public as to the realities of chiropractic.

. . . **Japanese Speakers Bureau** continues its fine work on the radio and TV programs in Japanese and adequate reporting of its committee activities. It works on a very modest budget and I hope they got everything they requested.

. . . **Television-Radio** is taking some hard looks at what is going on the educational TV programs. There has been discussion of conducting a survey along with the Neilson Rating survey to determine how many people are watching Medically Speaking, where they are watching from, and what socio-economic grouping is watching. The feeling generally is that the people who need the education the most, those in the lower socio-economic groups are watching much less than the upper group. There is a question as to what can be done to reach better those who need it most.

. . . **Cancer** continues to make gradual progress towards a more integrated regional cancer educational and treatment program. Mrs. Seberg reported to the Committee and the Cancer Commission on the fine work she has been doing, at improving the cancer registry at Queen's Medical Center.

Aloha.

JOHN BROWN, M.D.

Hawaii Academy of General Practice

. . . The Capitation Fee

This is the year of the big push in the Congress to revamp, to change completely the health care system in the United States.

The Kennedy–Reuther proposal has for its key concept the compulsory nationalization of medical care with physicians organized into panels to serve and be prepaid a fixed fee. The Nixon Administration's plan includes Health Maintenance Organizations (HMO) which will also have as their economic basc a prepaid capitation fee. The big differencc between the two proposals is that the latter are voluntary.

"Capitation" is thc tcrm used when the physician (or organization) is paid so much a head, c.g. if his "panel" of signatorics (patients) numbers 1,000, he will bc paid say $2 per capita—$2,000 per month—by the vendor. The vendor will usually be the Federal government. The physician is thcn expcctcd to perform all required scrviccs within the flat fee. In thc case of an HMO, the organization of physicians will have to provide all services AND hospitalization to bc paid out of the one kitty.

I worked within such a fixed fee system some 25 years ago, as a plantation physician on the islands of Lanai and Molokai. At first it was under the old plantation medical system, on a rctainer; this gavc way to an HMSA contract between pineapple plantations and HMSA in which the services of us physicians were purchased and we were paid by HMSA at a "capitation fee" of 25¢ per head —not $2! Being new to the practicc of medicine at the time, wc never did figure out whether we were overworked or overpaid! We do recall vaguely that the monthly remuneration was perhaps a little higher than the former salary had been. Having just come out of military servicc after a five year stint, as a physician on salary, these various systems—military, plantation, and HMSA capitation—seemed thcn to be very much one of a kind. Life, howcver, was quite pleasant, because of the many perquisites thrown in by the plantation.

The people—the plantation workers with their developing union—wanted a change, however. They wanted to get away from a paternalism under which the benevolent plantations supplied them with cradle-to-grave amenities. How strange it is that the people of the United States, they say—not just in Hawaii—now want to go back to paternalism of big government!

Twenty-five years ago, the capitation fee under HMSA was scrapped after a very brief period. Fee-for-service medical insurance, with management and labor both contributing to the payment of the premiums, and with the subscriber-patient paying a small amount of "co-insurance," came into being. It was a voluntary plan, though few could resist the obvious benefits. The worker-patient becamc emancipated. He became responsible for his own health and welfare and that of his dependents. He soon came to want and demand high class medical care, and he got it. It was inevitable that costs would climb. The primary cause was the consumer demand!

It is difficult for us who have traversed these pathways to understand how so many people in this country who have at one time or another experienced "capitation" medical schemes, have resented the kind of once-over-quickly care they received therein, yet now are gullible enough to be attracted BACK to those systems by promises offered by politicians. Millions have passed through military service and many through subsequent V.A. facilities; millions on welfare have had the experience of waiting long hours for "handouts" in hospital outpatient clinics.

The basic deficiency in all such fixed-cost systems is that the patient has no contractual right to demand the servicc he wants—and feels he needs.

Whenever a physician is paid a salary, or retainer, or capitation fee to cover his services in full, he naturally tends to become an 8-hour-a-day man. Only exceptional dedication to his profession will drive him to overcome the tendency to put his feet up on his desk and prescribe casually: "Go take an aspirin."

What is even worse is that the patient under such a system may rightfully think, with a valid degree of suspicion, that the care he is receiving is not the very best. The patient has no real way to tell whether his physician is deeply devoted to making him well, or just getting by. We know

continued page 210

Slants and Angles

HAWAII MEDICAL JOURNAL

Papaya Palms

Papaya is a popular breakfast fruit in the Islands. Many kamaainas eat one every day and extol its salubrious and healthful properties. The striking yellow-orange color of the papaya is largely due to its carotene content, one medium-sized papaya containing about 3 milligrams of this pigment.

Following prolonged consumption of papayas excessive quantities of carotene accumulate in the body, particularly in the skin, where the yellowish-orange pigment stains the palms, soles, and naso-labial folds. The serum carotene levels are greatly increased. The condition is termed hypercarotenemia. Carotene pigments are found in many other fruits and vegetables, including carrots and tomatoes. The human body utilizes them as precursors of vitamin A.

A large number of cases of hypercarotenemia were seen among the civilian population of Great Britain during the last war following exhortations by the government to eat large quantities of carrots. The populace was told that deficiency of vitamin A led to night blindness, a major handicap under blackout conditions, which could be prevented by eating carrots. Photographs of ace night-fighter pilots nibbling on huge bunches of carrots just prior to takeoff were prominently featured in the newspapers. Their success in destroying German bombers was attributed to cat-like nocturnal vision.

Later, alas! it was all revealed as a hoax, deliberately perpetrated by the British government to conceal the fact that their night fighters found the German bombers not by superior night vision but by the use of a top secret device known as radar.

Returning to the present, hypercarotenemia in Hawaii is almost invariably the result of papaya-eating, and seems to be most prevalent among the elderly Oriental population. This is probably because of their small total body mass and surface area. Once hypercarotenemia has been diagnosed, however, the common papaya-produced type must be distinguished from more serious conditions in which the serum carotene is elevated. These disorders include diabetes mellitus, the nephrotic syndrome, cirrhosis, hypothyroidism, and certain hypercholesterolemic states.

Carotene pigment does not stain the sclera, so the condition is readily distinguished from jaundice. A careful history will distinguish the rare cases of yellow skin staining following ingestion of picric acid, saffron, or mepacrine. The final diagnostic test is omission of papaya from the diet, following which the yellow discoloration slowly fades over several weeks or months and serum carotene levels return to normal.

Prodromes of Stroke

A familiar tragedy which we have all seen is the apparently healthy middle-aged person, felled in the prime of life by a massive, crippling stroke. In a certain percentage of cases these strokes result from atheromatous disease and narrowing of the extracranial portion of the carotid arteries. If a stenotic vessel is discovered early enough, a CVA may be prevented by corrective vascular surgery.

Often before a major stroke occurs, prodromal symptoms are experienced. Important prodromal symptoms are temporary unilateral blindness, transient hemiparesis, aphasia, dysarthria, and unilateral sensory changes. Aching in one shoulder may occasionally precede a stroke.

Careful examination of the neck vessels is mandatory in all patients with prodromal symptoms. A carotid artery bruit, best heard at the angle of the jaw, is an important finding and when present makes measurement of the retinal artery pressure and carotid angiography mandatory.

An essential part of the routine physical examination of any patient over the age of 45, particularly if there is a history of hypertension or a family history of cardiovascular disease, should be a careful examination of the neck vessels together with direct inquiry about possible prodromal symptoms.

Notable and Quotable

The following excerpt from Ernest Hemingway's *Death in the Afternoon* seems as pertinent today as when it was written 40 years ago:

"The bull gets death within 15 minutes of when the man starts to play him, and all wounds he re-

continued page 221

University of Hawaii

Yale departed from conventional medical teaching methods in the 1930's, when they instituted a program of no required examinations until the end of the second year, at which time satisfactory completion of National Board examinations determined the student's progression to the clinical (3rd and 4th) years. The rationale in this method of teaching resided in the idea that the student learned the various ingredients of the basic science courses because of *interest* and to enrich his lifetime knowledge, not simply to pass an examination.

In the 1930's and 1940's, a few other medical schools instituted similar liberal programs. Western Reserve pioneered in the practice of early student exposure to patients, and enabled each student to follow a pregnant woman through her delivery. This school instituted integrated interdisciplinary instruction at this same period. These early innovations presaged the considerable changes in curricula and methods of teaching which have occurred in most schools in the past 5 to 10 years.

There is enthusiasm for moving preclinical sciences into the undergraduate years, particularly for those students interested in getting on with the job early. Some courses, such as anatomy, have been shortened. At the University of California, San Diego, the departments of anatomy, biochemistry, pharmacology, and physiology do not exist as separate entities; the surgical department teaches gross anatomy and the pathology department teaches microscopic anatomy.

Electives are emphasized; in some schools, the entire final one and one-half academic years are devoted to electives, enabling a student to begin specialty training in a clinical science, or to go back to a basic science to perform research.

Some schools, such as the University of Washington, no longer make a clinical clerkship in surgery a requirement. They have found that they attract about 80% of the students to this subject as an elective, however. Also at Seattle, students may take any of four basic pathways in their progression through medical school and residency leading to careers as:

1. Family practitioners,
2. Medical scientists,
3. Medical specialists, or
4. Psychobiological specialists.

Some schools are also beginning to "collapse" the internship into the fourth year of medical school and have a residency begin upon the student's attainment of the M.D. degree.

The School of Medicine of the University of Hawaii, a two-year school, places strong emphasis on sound basic science groundwork, integrated with clinical exposure. Students see patients, in a course in history-taking, during their first week of classes. As they progress in this course, they soon begin to integrate the facts and concepts they are learning in genetics, physiology, and biochemistry. In their second semester, a course in physical examination coincides with those in anatomy, physiology, and biochemistry. In the year 1971-72, an existing trend to integrate major problems of physiology, biochemistry, and anatomy will be carried a stage further.

A unique feature of the Honolulu medical scene is a large repository of superbly-trained clinicians who span all the specialties, and who have been trained in various excellent medical centers in the U.S. and abroad. They are not bound as a group to the established pattern of thought or practice of any single school. Most are in private practice and have access to a broad spectrum of patients, and most are interested in teaching. Many of them have been receptive to giving voluntary time without remuneration to teaching in the School of Medicine. The teaching is of a tutorial or preceptorship type, the student or group of 3-4 students often actually seeing private patients in the physicians' private offices. This practical and intimate exposure to clinical cases has distinct advantage over the method of long theoretical lectures.

Among the Honolulu physicians participating as tutors in the course in physical examination are: dermatologists **R. Kim, H. Johnson, E. Emura, Goldstein, Caver, Fardal, Allison, A.**

continued page 221

X-ray View Box

HAWAII MEDICAL JOURNAL

• The 52-year-old gentleman whose films are shown below had a rather sudden episode of severe pain about his left shoulder of several hours' duration.

• There was no history of any recent trauma to his left shoulder area.

• What is your diagnosis?

• Answer below.



Fifty-five cubic centimeters of old blood was aspirated from the left shoulder joint space with immediate relief of symptoms and the patient had a full range of motion. There was no dislocation. The patient is being investigated for a bleeding diathesis.

Submitted by

D. R. GRININGER, M.D.
HAWAII RADIOLOGICAL SOCIETY

In Memoriam – Doctors of Hawaii

HAWAII MEDICAL JOURNAL

This is the ninetieth installment of In Memoriam—Doctors of Hawaii.

Franz Gill Edwards

Franz Gill Edwards, born in 1896, graduated from Harvard Medical School, Boston, in 1923.

In 1925 Dr. Edwards came to Kula Sanatorium as an assistant physician who is remembered as doing the first thoracoplasty on Maui. In the fall of the same year Dr. C. P. Durney, superintendent of Kula from 1912, was forced to resign due to illness, and Dr. Edwards succeeded him. Poor health forced Dr. Edwards' resignation in 1928, and he left for a coast residence. By 1934 he had located at Waldport, Oregon, where he practiced until his death on February 2, 1948, at the age of 52.



DR. EDWARDS

Dr. Edwards was a veteran of World War I.

Mars Laurice Madsen

Mars Laurice Madsen was born at Viborg, South Dakota, on January 30, 1898.

He graduated from Washington High School in Sioux Falls, South Dakota, and then attended the State College at Brookings and the University of Wisconsin. He received his M.D. from Rush Medical College in 1926. His internship was served at the Queen's Hospital in Honolulu.

Dr. Madsen began his practice in 1927 as a government physician at Hana, Maui, where he practiced for seven years. In 1934 he moved to Paia and the following year he practiced in Wailuku.

The doctor was married to Helen Hoobin of Alhambra, California, and their first son, Peter C., was born in the Islands.

In 1936, after ten years of island practice, Dr. Madsen returned to the Mainland due to ill health. There he practiced in Webster and Sisseton, South Dakota. In 1938 he took charge of the hospital at Canova, South Dakota.

Dr. Madsen died at Canova on January 8, 1944, within a few days of his 46th birthday.

He was a member of the Masonic Lodge of Howard, South Dakota, and the American Legion Post at Canova.

William Wesley Nesbit

William Wesley Nesbit was born in Roxbury, Pennsylvania, on March 26, 1902.

He received his M.D. degree from Jefferson Medical College in Philadelphia in 1926. In the same year he entered the public health service as an intern at the Public Health Service Hospital in Norfolk, Virginia.

Dr. Nesbit served as medical officer in charge of Service hospitals in New Orleans and Galveston, Texas. At one time he was chief medical officer of the U.S. Coast Guard Academy in New London, Connecticut.

From 1929 to 1934 he was the U.S. public health service in Honolulu.

During World War II, he served on the staff of the headquarters fleet of Admiral Chester W. Nimitz. For service in connection with the establishment of medical operations of the U.S. Naval Military Government for occupied areas in the Pacific Dr. Nesbit was awarded the Bronze Star.

From September 1952, until the time of his death, Dr. Nesbit was the medical officer in charge of the public health service hospital in Seattle.

His death occurred on May 7, 1953, in Washington, D. C. at the age of 51.

Harry Hood Whitten

Harry Hood Whitten, born in 1869, was a graduate of Northwestern University Medical School, Chicago, in 1896.

In 1923 Dr. Whitten was in practice in Peoria, Illinois. From 1929 to 1930 he was located in Honolulu, following which he returned to Peoria. By 1934 he had moved to Temple City, California.

Dr. Whitten died July 30, 1934, in Alhambra, California, at the age of 65. He was a former member of the Hawaii Medical Soeiety.

HAWAII MEDICAL JOURNAL

Book Reviews

WINFRED Y. LEE, M.D.

★Synopsis of Dermatology, 2d Ed.

By William D. Stewart, M.D., F.R.C.P.(C), Julius L. Danto, M.D., and Stewart Maddin, M.D., 445 pp., $13.85, C. V. Mosby Co.

HERE IS a book which should be within easy access of most practicing physicians! The authors have reduced a mass of information on the skin and related structures into a concise, authoritative compendium. Diseases are first considered on a regional basis, then by disease groupings: as allergy, bullous disorders, etc. The alphabetic listing of chapters provides prompt reference without detailed dermatological terms. When confronted by a patient with darkened skin, one flips to the chapter on disorders of pigmentation, where acanthosis nigricans, hemochromatosis, Addison's disease, and other possible diagnoses are discussed.

Photographs, including 49 color plates, are of uniformly good quality. Drug reactions, common and perplexing problems to most physicians, have a chapter all to themselves.

RICHARD W. FARDAL, M.D.

A Biographical History of Medicine; Excerpts And Essays on the Men and Their Work

By John H. Talbott, M.D., 1,211 pp., $60.00, Grune & Stratton, 1970.

THE FUN Dr. Talbott (ex-editor of *JAMA*) says he had while writing this shines out of every page. It further enlivens what was already certain—by reason of its format of concise biographical sketches, from Hammurabi and Aesculapius to Minot and Banting—to be an extraordinarily lively history of medicine.

Many of the sketches are already familiar to most American physicians, because they were all published in *JAMA* originally. But even the most faithful reader of *JAMA* will find pleasure in a leisurely return to them (who can be leisurely in perusing *any* medical journal?), either serially or at random.

At five cents a page, it is a fantastic bargain, and would be a marvelous gift, whether for someone else or just yourself.

HARRY L. ARNOLD, JR., M.D.

★The Hard of Hearing Child; Clinical and Educational Management

By Frederick S. Berg and Samuel G. Fletcher, 363 pp., $12.50, Grune and Stratton, 1970.

THIS BOOK IS designed for those interested in the welfare and education of the hard of hearing child. It brings together between the covers of one book information from many sources that bear on the problem. Among these, speech and hearing science, psychology, sociology, linguistics and professional education.

I found it interesting and informative, with a good bibliography at the end of each chapter. I can thoroughly recommend it for anyone whose interest lies in this field.

JOHN R. WATSON, M.D.

★ means highly recommended.

Physical Diagnosis in Cardiovascular Disease

Edited by Charles K. Friedberg, M.D., 362 pp., $13.75, Grune & Stratton, 1969.

THIS IS a compendium of articles which were first published in "Progress. in Cardiovascular Diseases" and which have been organized into a single volume by Dr. Charles K. Friedberg.

The techniques described range from simple inspection to such sophisticated techniques as ophthalmodynamometry. The authors attempt to correlate physical findings with such sophisticated ancillary devices as the phonocardiogram, jugular phlebograms, chest X-rays, carotid pulse tracings, impulse cardiogram, etc. The relationships are amply and graphically detailed by many illustrations in this well-written text. The identification of the basic mechanisms behind presenting physical findings, to me, represents the ultimate in the application of laboratory techniques to the practice of clinical medicine.

This book is again recommended to all practicing physicians but will probably be of most interest to students and teachers of cardiovascular physical diagnosis.

BERNARD W. D. FONG, M.D.

★Reconstructive Surgery of the Middle Ear

By Adolph Wolferman, M.D., 184 pp., illus., $25.00, Grune & Stratton, 1970.

A CONCISE TREATISE on tympanoplasty. The chapters on physiology, clinical pathology, and patient selection are recommended reading. The chapter on tympaniplastic surgery is excellent, presenting the authors procedures in correcting the common middle ear problems.

BARTON R. BECKER, M.D.

The New Psychology of Dreaming

By Richard M. Jones, Ph.D., 221 pp., $7.95, Grune & Stratton, 1970.

THIS BOOK is an attempt to amalgamate, and to some extent reshape, the major psychological theories of dreaming in view of the information now available through EEG and REM studies regarding the physiology of dreaming. As such, it does not so much present a new psychology of dreaming, but is more of a review of major dream theories and how they might fit into data which suggest that dreaming is a psychological response to the mammalian D-State. The book is valuable in that it gives the reader an overview of some of the more recent work in sleep physiology. In short but comprehensive fashion, the author reviews the salient features of a number of dream theories ranging from Freud to Piaget, Angyal, and Erickson. The author's interpretation of one of his own dreams in light of various theories is interesting, but these might well have been made if the EEG had never been invented. It is clear that a holistic, uniting psychophysiological theory of dreaming is some time in the future, if ever.

KWONG YEN LUM, M.D.

HAWAII MEDICAL JOURNAL

Notes and News

HENRY N. YOKOYAMA, M.D.

Life in These Parts

Outgoing HMA president **John Lowrey** recently enunciated one of the most challenging, practical, and profound concepts of recent years with his "Changing Concepts of Death." John outlined circumstances in which an aging or ill individual, while still competent, should state when efforts to sustain him should cease, and suggested that such a statement, handled like a will, would provide guidance for families, pastors, and physicians. . . . We knew John to be a man of integrity and seriousness, but did not realize just how much until we learned that he had told his wife, "If you don't honor my instructions, I shall come back to haunt you." (And that's seriousness. . . .)

Our just occasionally vitriolic executive secretary, **Tom Thorson,** received a hotel reservation form for the 12th Annual Conference of the United Foundations for Medical Care, to be held in June on Kauai. When he came to the rather offensive inquiry, "Rooms, Share Twin.....; Single.....; Other (specify)..... (Please give name of roommate if other than spouse)," he was heard to sputter, "None of your damn business. . . ."

In recent weeks, we have been pleasantly surprised by the constantly changing profile of affable **Keichi Goshi.** We first commented on the lengthening side burns and suboccipital tresses, and he laughingly explained, "I simply stopped going to the barber." More recently he has sported a full beard and mustache and he explained modestly, "I simply stopped shaving, too." (He vaguely resembles the samurai physician in the Kurosawa movie "Red Beard.")

We have mentioned how Kuakini Hospital's associate pathologist **Frank Fukunaga** has been called many names, but judging from the typographical errors we wonder how some of the mail ever reaches him. Herein are a few more examples: "Dr. F.H. Furwaga, Assoc Path"; "Dr. Mutunaga Dep of Clinical Chemistry"; Dr. F.H. FUN 347 North Kuakina St."

One day, we noticed **Harry Arnold's** car loaded with rugs. Harry, looking chagrined, explained, "Remember how we were flooded out several years ago in Kahala? Well, we moved recently to a 3rd floor high rise apartment and got flooded out again." (It seems that a drain was plugged and water came through the air conditioner.) Says Harry ruefully, "If only I had consulted the astrologists earlier, I would have known. . . ." It seems that Harry is Leo and Aquarius is directly opposite Leo. . . . Our fates are in the stars. . . .

We met **K. C. Chock,** our diminutive, ageless, trim, spry dean of local practicing physicians, and learned that at 76 he still plays three man volleyball, using the full court at the "Y" at least three times a week. . . .

Taken from Eddie Sherman's Column in the *Advertiser:* "Some hippies may cheer, but many tourists will be taken aback by the ad for campers in a local tourist publication which starts out with typographical disaster: 'Did you know there are over 20 *pubic* campsites on Oahu?' " (Italics are ours.) . . . "A gentleman looking for a dog noted that yesterday's want ads included a 'Boston Whaler' under 'Pets for Sale.' "

The 3rd Annual Makaha Invitational was held on the Easter vacation weekend with 16 participants, under the auspices of **Paul Tamura** and **Frank Fukunaga.** The event was won by irrepressible **Hideo Oshiro,** who seemed to be limping rather badly because, in his own words, he had fractured his right toe "following a hassle with a dog." His wife, Lillian, later revealed that he had simply hurt his toe kicking a recalcitrant dog. Other winners included **Manuel Abundo** with a creditable net 72 and **Coolidge Wakai** with a net 74. Tied for last place were **Francis Oda** and **Paul Tamura** with simply incredible scores. . . .

When **Arnold Gould,** pediatric neurologist from Columbia, was here last year, he lectured on minimal brain damage and confessed to his own motor coordination defect. He told how he took golf lessons twice daily for one month from Chi Chi Rodrigues with nary an improvement. It was then that Children's Chief of Staff **Henry Yim** made the observation, "Any person playing golf five years and not breaking 100 may be construed to have minimum brain damage," which came to be known as "Yim's Law." Recently Henry Yim, himself, appeared worried for he had not broken a 100 at Mid Pac CC and confessed, "I must be brain damaged." We reassured him that Mid Pac was a tough course, but we marvelled at his courage in admitting to minimum brain damage. Most of us are loath to admit this affliction and delude ourselves by blaming the terrain, the weather, the greens or our opponents. . . .

State Health Department Chief **Walt Quisenberry** listens regularly to Aku ("One of the world's two best disc jockeys") and was quite unhappy that Aku criticized him for not taking action on reports that local fish cake had high levels of mercury. Then U of H's **Dr. Siegel** announced that one would have to eat at least 50 lbs. of fish cake in a day or two lbs. of fish cake daily for 10 months to reach tissue toxicity levels. Walt was overjoyed because his favorite disc jockey, Aku, reversed his position and publicly apologized with "He knew what he was doing. . . ."

Gleaned by **Heather Akana** from the *Advertiser,* April 8, under "Thoughts for Food": A recipe for "*crap* dip elegant. . . . Serve hot with potato chips or corn chips. . . ." (Food for thought?)

From Ed Childs' Collections

A gynecologist informed a girl that she was pregnant. "But doctor, why? I haven't even been near a man." The doctor moved over to the window and gazed intently into the heavens. Asked the girl curiously, "What are you looking for?" "The last time this happened, there was a star in the East."

A woman medical student was asked by her instructor, "What part of the anatomy increases 16 times its size?" She blushingly replied, "The penis." She was properly reprimanded. "The correct answer is the pupil. You haven't been studying your anatomy lessons, and someday you may be in for a big disappointment."

A preacher was prone to speak on subjects on which he did little research or had little experience. One day he told his wife he would talk on water skiing for his Sunday sermon. Saturday night, unable to find much inspiration, he decided to fall back on an old standby, "Sex," but didn't tell his wife. On Monday, the preacher's wife was stopped by an enthusiastic parishioner who complimented her husband for the excellent sermon which showed experience, practice, and first hand knowledge. Commented the preacher's wife, to the parishioner's

understandable consternation: "I don't understand. He has done it only twice. Once before and once after our marriage, and both times he fell off. . . ."

Re his own X-ray reports: **Ed Childs** says, "We can't always make the diagnosis, but we go as far as we can." (His own Errol Flynn philosophy.)

A famous French skier was being interviewed after winning a grueling ski tournament. "What will you do first?" "I will first make love to my wife." "What next?" "I will make love to my mistress." "What after that?" "Then I will take off my skis."

Doctor: "Mrs. Atherton, I have good news for you." "Pardon me, but it's *Miss* Atherton." "Then I have bad news for you."

The Hungarian peasant was stung by a bee on an intimate part of his anatomy. He rushed to the doctor. "Please Doc, ease the pain, but leave the swelling alone."

A poor lecturer, noting the disinterested audience, interrupted his talk and inquired if those in the back row could hear him. When someone from the back replied, "No," those on the front row promptly got up and moved politely to the back row. . . ."

AMA-ERF Benefit at Princess Kaiulani

(6:00 to 8:00 p.m.) No host cocktails, pupus, silent auction. . . . **Fred Shephard** with straw hat selling booze tickets. . . . **Don Jones,** master barker. . . . Women busy bidding on intricate ceramic figurines by **Faith Ishii** et al. . . . We did not see an **Ed Yamada** painting this year. (One went for 350 dollars to **Akira Kutsunai** last year.) . . . **Marj Yoshida's** Brassaia bonsai. . . . Yosh really did not have to badger us into bidding. . . . Frantic bidding between A. L. Kilgo and **Kenneth Gardner** and others including **Dot Salcedo.** . . . Saved **Gordon Chang** from bidding $17.00 for a Marj Yoshida creation by introducing him to its creator. . . . Bid $1.00 each for two scraggy plant miniatures and got stuck. . . . Busy bar with only two bartenders and long waiting lines. . . . Overheard **John Smith** saying, "We'll never have alcoholics with these bars." **K. S. Tom** cornered us with a pretty boutique auctioneer. . . . **Diek Ho** had entreated us to purchase Anita's lichee pupus and we found them excellent. . . . **Frank Fukunaga** and **Art Salcedo,** who lost to us in the afternoon's golf match at MidPac, very generously plied us with drink and pupu. . . . Frantic last-minute bidding for the various items, but friends carefully refrained from outbidding each other. . . . Dress: Mostly mod and casual, but there are always a few who somehow didn't get the word. **Henry Yim** looked rather sheepish in coat and tie until **Charley Ching** came similarly dressed. Overheard them exchange, "Thank goodness, you're dressed."

Welcome speech by **Anita Ho** thanking her two hard-working co-chairwomen **Jean Chang** and **Myrna Chun-Hoon.** . . . Anita's Ode to **Tom Frissell:** "Tom, Tom, Medical County's son. . . . Started his term. . . . And projects did run. . . . The projects thrived. . . . And Tom was beat. . . . But today we're glad. . . . Tom's still on his feet. . . ." Tom wearily got to his feet and mumbled something about the fine spirit and appreciation for the affair . . . too old and tired to be put back to work! We were treated to **John Smith's** repertoire of "Drunk Stories." (Glib, straight faced, master comedian.) . . . Examples: Drunk asked the bartender for "something tall, sexy, thirst quenching and smooth." Bartender: "Here, take my wife."

Drunk driving down a one-way street. Cop stopped him and said, "Can't you see the arrows?" "Hell, I can't even see the Indians."

Drunk at the bar started to yell, "Happy New Year!" A friend: "This is the 4th of July."

Drunk: "My wife will kill me. . . . Never been out this late before. . . ."

Dance Contest: Conducted by Arthur and Kathryn Murray. Versatile MC Kathryn told some of her "Arthur" stories: "Arthur should really be up here because he loves to listen to doctors. . . . I once got him a wrist watch and he refused to wear it because it had a radium dial. . . . You notice Arthur does not smile easily, but inside he's happy. . . . Only, his face has not gotten the news. . . . You may think we have disagreements, but we usually don't. . . . The only real disagreement we had was about our wedding. . . . You know how girls are about big weddings and so forth. . . . Well, Arthur just didn't want to get married at all!"

Kathryn, as you know is rather diminutive and alluring and tells this story: "I boarded a crowded bus one day and was standing next to a tall gentleman. . . . I kept fumbling with my purse to get change for the conductor and somehow couldn't get the purse zipper open. . . . Finally the tall gentleman noting my difficulty, offered to pay my fare. . . . 'But I can't accept that from a total stranger,' she protested. . . . Whispered the tall gentleman, 'We can no longer be strangers when you've already unzippered me three times. . . .'"

Dance contestants chosen: **Wini Lee** with **Jacqueline Jones; John Kenward** (visiting pediatrics professor) with a Mrs. Simpson (blond kitten) got most of the applause; **George Ewing** had **Mrs. Canete** for a partner while Danelo Canete also danced with Mrs. Simpson. Kathryn Murray called on **Ralph Cloward** for a fast Viennese waltz with her. . . . Ralph got up rather stiffly on his surgerized knee, but once on the floor, was the epitome of grace . . . smooth as silk . . . as smooth as his bald top. . . .

The real highlight of the evening was the Musical Depreciation—by The Floating Ribs (**Ed Kagihara, Bill Hindle, Bob Lee,** and **Jerry Tucker**) with pantomine renditions (hilarious, well timed, wacky, all adjectives, inadequate to describe their skill and comedy) of Spike Jones' Aloha Oe, Cocktails for Two, and other numbers. . . .

Men's Fashion Show: Arthur Murray hastily put on a T shirt with the inscriptions: "Very Old Men Need Love Too." MD contestants included **Ted Chun, Sam Waxman** in velvet pants, **Dick Ho, Ray Fujikami, Don Jones,** and **Ed Chesne** with "See Thru Pants."

Kuakini Oncology Conference

Tom Fujiwara described the findings in a 95-year-old man with gastric carcinoma extending from the esophagus to the pylorus and causing partial obstruction. Pathologist **Grant Stemmerman:** "Let's give him his poison (referring to 5-FU therapy). We agreed to dispense with **Fred Ansfield's** 70-year age limit only last week." Tom asked suspiciously, "With tongue in cheek?" Grant: "Yes, deep in cheek."

A malignant mesonephroma of the ovary in a 64-year-old woman was described as being the size of an 8-month-pregnant uterus. Someone wondered how she could go so long without knowing she had such a tumor. Moderator **Quint Uy:** "I recall in my internship examining a girl who was full term and did not know she was pregnant. Even her mother didn't know." **Grant Stemmerman:** "It was *very* large. . . . I would say she does not have a hopeless prognosis. . . . I prefer a combination of progesterone with 5-FU if it recurs. . . . It is a fairly uncommon tumor." Radiologist **Carl Boyer** disagreed: "We've treated three or four such cases since I've been back. It is not as uncommon as I thought. The prognosis is bad. As far as I know, surgical excision is the treatment of choice." (Note carefully the unanimity of opinion among our experts.)

A 64-year-old man with Ca of the prostate with Rt inguinal extension and bony metastases had an ileal loop done and was to be started on stilbestrol therapy. Stemmy, who had recently returned from two weeks in Japan, reported that comparative studies with Dr. Akazaki from Aichi Cancer Institute on routine autopsies in Japanese men over 50 show that men in Japan have

continued page 212

New Members



Truman E. Long, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

INTERNAL MEDICINE

Stanford School of Medicine—1961
Internship—Harbor General Hospital, Torrance, California—1961-1962
Residency—Harbor General Hospital, Torrance, California—1962-1965



Eunice J. Larson, M.D.
Kauikeolani Children's Hospital
P. O. Box 3799
Honolulu, Hawaii 96812

PATHOLOGY

Washington University, St. Louis, Missouri—1964
Internship—University Hospital, Seattle, Washington—1964-1965
Residency—Children's Orthopedic Hospital, Seattle, Washington—1965
Cedars of Lebanon Hospital—1966
Children's Hospital of L.A.—1967-1968



Gene W. Doo, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813

ENT

Jefferson Medical School—1965
Internship—York Hospital—1965-1966
Residency—Ohio State University Hospital—1966-1970



Allan K. Izumi, M.D.
888 South King Street
Honolulu, Hawaii 96813

DERMATOLOGY

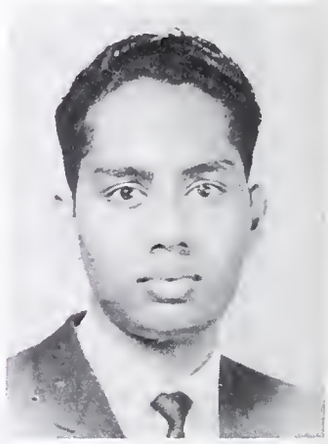
University of California Medical Center—1965
Internship—San Francisco General Hospital—1965-1966
Residency—University of California Medical Center—1966-1968
University of Pennsylvania—1968-1970



Russell R. Carlson, M.D.
888 South King Street
Honolulu, Hawaii 96813

ANESTHESIOLOGY

University of Illinois—1964
Internship—Cook County Hospital—1964-1965
Residency—Kapiolani, Queen's, St. Francis—1967-1968
University of Illinois—1968-1970

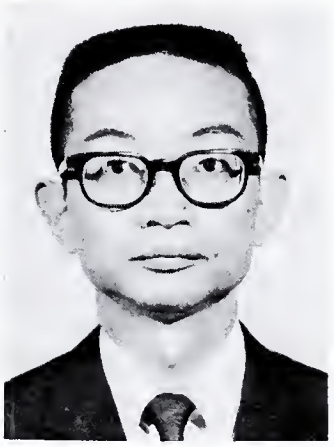


Anandom Hariharan, M.D.
2180 Main Street
Wailuku, Maui 96793

UROLOGY

Stanley Medical College, Madras, So. India—1964
Internship—Berkshire Medical Center Pittsfield, Mass.—1964-1965
Residency—Berkshire Medical Center —1965-1966
Wilkes-Barre General Hospital, Penn. —1966-1969

HAWAII MEDICAL JOURNAL



Tadao Nagashima, M.D.
101 Hualalai Street
Hilo, Hawaii 96720

GENERAL, THORACIC &
VASCULAR SURGERY

Kobe Medical College, Kobe, Japan—1956
Internship—St. Francis Hospital, Hi.—1957-1958
Weld County Hospital, Greeley, Colorado—1958-1959
Residency—Creighton University Medical Center, Omaha—1959-1960
Springfield Hospital, Massachusetts—1960-1961
Broaddus Hospital, W. Virginia—1961-1962
Glenwood Hills Hosp., Minnesota—1962-1965
Tucson Medical Education Hospital, Arizona—1965-1967
Baylor University Medical Center, Texas—1967-1968

Trent
Medical Personnel Bureau
521-2948

LINDA LOUISE TRENT—*Executive Director*

"Serving the Personnel Needs of the Medical Profession"

- **HOSPITALS**
- **CLINICS**
- **EXTENDED CARE FACILITIES**
- **CONVALESCENT HOMES**
- **RESTORATIVE DEPT.'s — O.T.S.'s & P.T.'s**
- **MEDICAL AND DENTAL ASSISTANTS**
- **LABORATORY AND X-RAY TECHNICIANS**
- **RNs-LPNs-NURSES AIDES**
- **HOME CARE AIDES AND COMPANIONS**
- **OFFICE PERSONNEL**
- **MEDICAL SECRETARIES**
- **MEDICAL STENOGRAPHERS**
- **MEDICAL AND DENTAL RECEPTIONISTS**
- **MEDICAL RECORDS LIBRARIANS**

Personnel carefully screened, evaluated and references verified.

24 HOUR SERVICE
521-2948

Hawaii Licensed Private Duty Registered and Practical Nurses.

1131 Kapiolani Blvd.—Room 407
Hawaiian Life Insurance Bldg.

Open Saturdays
8 A.M. to 12 Noon

Monday thru Friday—8 A.M. to 4 P.M.
Closed Holidays

Carnation
EVAPORATED MILK

HAWAII'S HEALTHY BABY MILK...



1970
Carnation Healthy Baby Contest
$1,000 1st prize winner,
David Culver Holbrook
of Honolulu, Hawaii



1st CHOICE FOR INFANT FEEDING...
No. 1 in the Islands for generations,
...available everywhere in Hawaii

"from Contented Cows"

County Society News

HAWAII MEDICAL JOURNAL

Hawaii

The March 26 meeting was held at the Waimea Inn. Nineteen members were present; fifteen were accompanied by their wives. Also in attendance were speakers, Mr. Frazier, a plantation manager, and members of the Advisory Board, Dr. Berry and Mr. Gunderson.

Dr. Paul Matsumoto graciously arranged this monthly meeting with the Society as guest. He conducted the program portion of the meeting introducing Dr. Ralph Berry who is in charge of the State Hospital System on the staff of the Board of Health.

Dr. Berry stated his opinion that the Waimea Hospital would not be built until the northern half of the island decides where they would like to have it located. It would seem at the present time the political situation is such that there is a diversion of opinion.

Dr. Matsumoto then introduced Mr. W. Gunderson of Bishop Trust. He stated that the Bishop Trust has a certain amount of money to spend on a hospital. He explained the steps he had taken in an attempt to get the hospital. He found there is still strong political sentiment for location at Honokaa, and expression from the group of doctors who live in the Waimea, Honokaa, Kohala area was requested by the chairman. The majority seemed to favor the Waimea site. Mr. Gunderson and Dr. Berry assured those present that continued efforts would be made to get the hospital project going.

It was announced that physicians of the Society would soon receive a proposed change in the bylaws changing the Board of Censors to a Medical Practice Committee. The proposed amendment will be discussed at the next monthly meeting. A letter is being sent to Dr. Quisenberry requesting a Physician Director for the Island of Hawaii. Dr. Adams suggested that the County Advisory Committee of the County Hospital System should have at least one or two physician members. No action was taken.

Dr. Matsumoto brought up the problem of satellite hospital libraries and moved that we send the request to Mr. Keifer for a designation of financing of them. It was passed by unanimous consent. Dr. DeWitt Smith was elected for the third delegate to the HMA meeting in April.

Discussion was held on the scholarship policy of the County Medical Society. Dr. Allan Takase, treasurer, is particularly interested in this problem. He has been asked to put down his suggestions in writing.

It was announced that the Planned Parenthood wishes to arrange for a clinic in Hilo. It was decided that this problem be turned over to the Hilo doctors.

* * *

A special meeting was held on April 6 at Hilo Hospital with 31 members present. Guest speaker, Dr. Leonard Scherlis of the American Heart Association, gave a most interesting lecture on cardiopulmonary resuscitation.

* * *

A meeting was held at the Hilo Hotel on April 22 with 13 members and two nurses from Hilo Hospital in attendance. Dr. Kenneth M. Moser, Director of the Pulmonary Division School of Medicine, University of California, San Diego, was guest speaker. He gave an informative and interesting lecture regarding pleural effusions.

Dr. Peter Alan Fleming's application for membership to HCMS was unanimously approved.

Members were advised to read and be prepared to vote on proposed amendments to the bylaws of the Hawaii County Medical Society at the next meeting. Amendments to alter: Chapter III, Section 4 (c), and Chapter IV, Section 3 (b).

Honolulu

Approximately 110 members were present at the March 4 meeting. Introduced were new members Dr. Truman Long and Dr. William Miller.

Woman's Auxiliary president Mrs. Richard Ho reminded the doctors of the coming AMA-ERF annual benefit dinner to be held March 27 at the Princess Kaiulani Hotel.

Speaker for the evening was Bob Sevey, News Director of KGMB. His subject for discussion was "Anatomy of a News Cast." A question and answer session followed Mr. Sevey's presentation.

An announcement was made of the Regional Medical Program of Hawaii's sessions for physicians on a "Physician's Role in Coronary Care" March 18-21 at the Hawaii Medical Library.

The doctors were also encouraged to attend a symposium on Arthritis sponsored by the Medical and Surgical Committees of the Arthritis Foundation March 15-17 from 9 to 12 noon at the Hilton Hawaiian Village.

Dr. William Goebert reported that the Society's Inter-Professional Relations Committee has suggested at the request of the lawyers, that we have an informal get-together of the lawyers and doctors with wives and families to be held on Coconut Island. A postcard poll will be taken of the entire membership regarding participation in such an activity. More information on this event will be forthcoming.

Dr. Winfred Lee and Dr. Thomas Frissell presented to the membership testimony they had presented to the Legislature regarding their views on the matter of a four-year medical school. They wanted to clarify to the membership that their testimonies were given as private physicians and not as representatives of the medical society.

Mr. Thorson reported that a letter sent out recently to the membership by the Malpractice Insurance Committee announcing the availability of malpractice insurance coverage for the doctors did not mention some of the responsibilities that will be assumed by the Association in the administration of this program, one of which involves the area of peer review. He stated that the committee stands ready to represent the doctors in this area, but he would like to emphasize that in the event the insurance company questions a physician's insurability, the committee will review the matter and make a recommendation to the insurance company on the physician. The committee will also review all claims to determine whether or not they should be settled or contested. He stated that he was happy to say that the Argonaut Company is not asking for a minimum participation of the physicians. He further stated that this is the official sponsored program of the Hawaii Medical Association. Doctors who are not now covered are urged to participate in this program.

continued page 220

"I'M FEELING
MUCH BETTER, DOCTOR."

"SO AM I."



HMSA is the "get-well card" that leaves you *both* feeling better. Offers patient and physician lasting relief from medical economic problems. Once again, March, July and November are individual enrollment months. An excellent time to remind unprotected patients about the benefits of belonging to this non-profit community organization. It's good for what ails them. And you.

Hawaii-owned for Hawaii's own
HAWAII MEDICAL SERVICE ASSOCIATION
BLUE SHIELD PLAN FOR HAWAII
Member Western Conference of Prepaid Medical Service Plans

HONOLULU: 1504 Kapiolani Blvd., P. O. Box 860, Phone 944-2110
WAILUKU, MAUI: P. O. Box 956, Phone 323-912
LIHUE, KAUAI: P. O. Box 27, Phone 245-3393
HILO, HAWAII: P. O. Box 1356, Phone 935-5441
KAILUA-KONA, HAWAII: P. O. Box 1219, Phone 329-3030

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

April 9, 1971 — 5:00 P.M.

Mabel Smyth Conference Room

PRESENT:

John J. Lowrey, presiding; Herbert Y. H. Chinn, R. Varian Sloan, Thomas P. Frissell, Grover H. Batten, William W. L. Dang, William E. Iaconetti, Yonemichi Miyashiro, plus Drs. George Goto, Cesar B. deJesus, Winfred Y. Lee, Calvin C. J. Sia, John Watson, J. Mark B. Sowers, J. I. F. Reppun, J. Brown, and Richard Fardal.

MINUTES

ACTION:

It was voted to approve the minutes of the February 12, 1971, meeting as circulated.

COMMUNICATIONS REQUIRING ACTION

Correspondence from Richard D. Moore, M.D.: Correspondence was received from Dr. Moore relative to his resignation as Councillor to the HMA.

ACTION:

It was voted to accept Dr. Moore's resignation and that a Councillor be elected at the House of Delegates' meeting to fill his unexpired term of two years.

Correspondence from Dr. Paul J. Sanazaro: A letter was received from Dr. Sanazaro on March 26, 1971, asking whether the Hawaii Medical Association is interested in becoming an experimental review organization. A draft of a letter indicating HMA's interest in answer to Dr. Sanazaro's request was circulated, reviewed, and discussed.

ACTION:

It was voted to approve the letter as drafted and that it be sent out immediately.

Correspondence from Dr. Edward O'Rourke: A letter was received from Dr. O'Rourke asking the HMA Council to reconsider its previous action relative to the University of Hawaii School of Public Health's proposed Hawaii Research and Development Program for Improved Health Services.

ACTION:

It was voted that HMA support a six-month feasibility study dealing with the health delivery system in Hawaii provided—

1. **that our representative members of the governing Board shall be selected by HMA;**
2. **that involvement of our membership at large in the studies is made known to us before the fact;**
3. **that all protocol and methodology are submitted to the Board for evaluation and comment before implementation and all data collected are submitted for evaluation and comment before release;**
4. **that the HMA Board members shall be contacted before our membership on any island is contacted; and**
5. **that approving the feasibility study does not *ipso facto* commit us to support any Health Services Research and Development Project.**

There were two dissenting votes, Dr. Batten and Dr. Frissell.

Correspondence from Hawaii Foundation for Medical Care: A letter was received from the President, O. D. Pinkerton, M.D., of the Hawaii Foundation for Medical Care relative to a loan in order that a full time Executive Director may be hired to fill the position of the late Mr. William Bowman.

ACTION:

It was voted to approve a loan guarantee up to $5,000.00 for 1971.

REPORT OF THE SECRETARY

The report was circulated, reviewed, and discussed.

ACTION:

It was voted to approve the Secretary's report.

REPORT OF THE TREASURER

The Treasurer submitted for review the committee budget requests which will be acted upon at the House of Delegates meeting. The following recommendations were made:

Public Relations Committee: Add $200 to the hospitality expenses for the 12-month (1972) request.

School Health Committee: Delete the $500 for transportation to the AMA Meeting from the committee request.

Disaster Committee: Increase the 6-month request to $50 and the 12-month request to $100.

Requests from committees relative to transportation funds to the AMA meetings.

ACTION:

It was voted to increase the general transportation fund by $1,000.00 for the 6-month period ending December 31, 1971, and increase by $2,000.00 for the 12-month period ending December 31, 1972.

Medical Education Committee: There was considerable discussion about office care seminar and whether or not the results of this seminar will be circulated to the membership. The committee requested $5,000.00 to carry out this portion of the Study.

ACTION:

It was voted to accept the $5,000.00 request for the present time and that the committee look for funds from other sources which shall be approved by Council.

Publication Committee: It was reported that the HAWAII MEDICAL JOURNAL is undergoing revision of its format, and Dr. Arnold, Editor, would like to do further work in revising the HMJ format. The committee requested $300 for the 12-month period.

continued page 211

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: BETTY BELL, *Vice President:* NOEL EVANS, *Secretary:* NOLAN HASEGAWA, *Treasurer:* RICHARD HORI, *Board of Directors:* C. CACHERO, H. T. CHEE, B. CHOCK, E. ELKE, F. FRICK, R. NAITO, W. OGOMORI, J. TARASAWA, A. YEE, C. YEE.

The President's Corner

As I sit and review this past year retrospectively, I wonder how I might have done more to redirect the complacency among my colleagues—to reduce the gap between the ideal practice of our profession and reality. Must we in the health professions be so involved in competitive struggles that we entirely miss the opportunity to complement each other's activities with an aim of relieving at least the most gross shortages?

The status quo of all health professions is threatened by the changes experienced in the development of third party payment plans. We in pharmacy in Hawaii have just felt the first blows of lay price-fixing via the present title XIX reimbursement policies—policies not defined, discussed or researched with pharmacists of Hawaii who are required to provide the services.

It is my personal opinion that we must *fight* for what we know is right and in the best interest of the public health. Let's accept the challenge of special interests, ignorance and greed. Toward this end we have created a HPhA Peer Review Committee to work with HMSA and the Department of Social Services to insure fair and equitable benefits to the patient, the pharmacist and the state (taxpayer). The committee can serve meaningfully only with your help and cooperation. There is an old adage that "God helps those who help themselves"—Well!! There is strength in numbers, with one Voice we can at least have a say in the determination of our future.

All Association Board meetings are open to the membership. Join us on the second Friday of each month, 7:30 p.m. at Queen's Hospital. Make your wishes known.

You elect the officers and members of the Board, you have the right to expect their full attention and service to their obligations or demand their resignation. They must know your wishes, however.

Pharmacy is *our* chosen profession, and it can be only what we make it in Hawaii.

EXCERPTS

The information proposed by Barker and Valentino for inclusion in the official compendium makes a lot of sense to this pharmacist.

In a society of over zealous laity looking for a cause to sue and the ever increasing demands by the public for clinical patient consultation from pharmacists, an official compendium containing such information as special storage or package instructions; side effects and interactions of which the patient should be aware; administration technique and adjuncts to therapy would be a valuable addition to our armamentarium.

PLAUDITS

Our collective appreciation to Program Chairman Henry Urashima and Capt. Crawford for a very successful Quarterly Meeting at the Tripler Officers' Mess.

I wish that you all might have shared our recent annual meeting, April 9-12. It was a real learning experience. Our thanks to chairman Omel Turk, Mrs. Ira Holway, University of Hawaii College of Continuing Education and their respective co-workers.

The DDD Golf Tournament April 22 was well attended. Our grateful appreciation to Richard Yoshino, Walter Murakami and Albert Chang.

REMEMBER—Set JUNE 23, 1971 aside. Now let's show your new President, Noel Evans, you're really behind him!!

PERSONNEL PLACEMENT

Your executive secretary is receiving numerous queries from registered pharmacists on the mainland. Interested? Give her a call or write the HPhA Office.

Legislation

SB-470 HB-580 "A Bill for an Act Relating to the Qualifications for Licensure as a Pharmacist" . . . recognizing out-of-State internship time passed both the house and the senate and at this moment awaits he Governor's signature. Plaudits to our legislative committee. Mahalo nui.

Federal-Controlled Substance Act will take effect May 1, 1971. All pharmacists have received detailed information from BNDD and the A.Ph.A. We intend to reiterate only the areas of the law here that are substantially different from the present Harrison Narcotic Act.

1. *Every* person who manufactures, distributes, or dispenses any controlled substance must re-register with BNDD.
2. *All* registrants *must* inventory controlled substances in schedules II, III and IV on May 1, 1971, retaining record for review for 2 years.
3. Separate records must be maintained on Schedule II drugs—invoices and dispensing records.
4. Collective records may be maintained on Schedules III and IV drugs if invoices and dispensing records are identified by a 1" letter C in red on the record.
5. Administration label on Schedule II, III and IV must contain the name and address of the patient, date of filling, name and address of pharmacy, name and registration of practitioner, as well as the transfer legend "CAUTION: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."
6. The pharmacist may now dispense schedule II (old Class A narcotics) in emergency situations on a telephone order from a physician. The physician must provide the pharmacist with a written order within 72 hours. The pharmacist *must* report the physician to BNDD if he does not do so.

7. A schedule II order may now be partially filled and then completed within 72 hours.

8. *Only* pharmacists may sell schedule V drugs (OTC exempt narcotics). He must make sure that the recipient is 18 years of age and intends the use of the drug for medicinal purposes.

9. *Only* schedule II drugs are to be ordered on official order forms.

10. Briefly the new schedules are as follows:
 Schedule I—hallucinogenic and narcotic substances having no known medical use.
 Schedule II—old Class A narcotics.
 Schedule III—old Class B narcotics and stimulant and depressant drugs formerly contained under DACA.
 Schedule IV—tranquilizing drugs and long-acting barbiturates having less abuse potential than schedules II and III.
 Schedule V—old exempt narcotics.

Health Professions Educational Assistance Legislation. Pharmacy colleges have been eligible for funds for construction, for scholarships and loans for students, and for institutional and special projects for the past two years. On July 1, 1971 they will receive a grant of $9.6 million.

The AACP requests Association endorsement of H.R. 4171 and S. 934 introduced by Representative Haggers and Senator Kennedy respectively—as the best overall bills for the health professions. Your Board of Directors feel we must support pharmaceutical education bills if we expect pharmacy colleges to keep up with the expanding need for pharmacists.

Proposed FDA Ruling on Combination Drugs for Human Use.—Your Board of Directors voted unanimously to oppose a FDA policy ruling that would essentially remove all combination drugs from the market place.

We object because we feel that the attending physician has a right to utilize combination drugs he has found clinically effective for his patients; and that the practicing physicians should at least be consulted—since he could still require his pharmacist to compound his favorite combination—very likely resulting in a costly product to the patient.

Should the physician prescribe the desired items individually, the patient is doubly inconvenienced and will likely pay more for two prescriptions than one.

We respect the FDA's obligation to improve patient care and preserve the public health but we question the degree of their involvement in the practice of medicine.

In fixed combinations of single ingredients proven to be safe and effective and tested for adverse drug interactions and stability, we question the wisdom of utilization of investigational talent, facilities and funds to produce additional clinical data supporting combination effectiveness.

Have you tried medicating a child with a cough, tight chest, and a runny nose? You're lucky to get one dose down him—let alone several.

Drug Abuse Committee

Chairman James McElhaney and his committee have worked diligently to support the Association's position that the Pharmacist belongs in the *front line* of any Drug Abuse Program. The pharmacist is imminently well qualified to "tell it like it is" and more apt to see the "user" before the physician. Hopefully, in time to give correct information and direct the user to the agency that can best meet his need. Neither the "Commission on Dangerous Substances" chaired by Charles W. Stewart, M.D. or the Advisory Committee to the Office of the Attorney General on the Uniform State Controlled Dangerous Substances Act chaired by Louis J. Casarett, Ph.D. utilized the services of a representative of organized pharmacy. It's time for a change. Therefore, Mr. McElhaney presented the following testimony in support of Senate Bill 1016—for the establishment of a State Commission on Drug Prevention, Treatment, Information and Education, and Rehabilitation.

"I am James Lee McElhaney representing the Hawaiian Pharmaceutical Association. Our organization is in favor of the formation of a Commission to coordinate programs dealing with dangerous substances. We are in accord with the concept of such a Commission as expressed in S.B. 1016 and in the Report of the Hawaii Committee on Drug Abuse.

Section 1 of S.B. 1016 describes the "limited success" of past State attempts to curb substance abuse which has led to the proposal of a coordinating Commission. In December 1969 the private sector recognized a need for a coordinating agency. They failed, or enjoyed "limited success," in their attempts, and an examination of the reasons for failure should be valuable to the committee.

The voicing of a "Call for Community Action" by the Hawaii Medical Association in January 1970 resulted in an Ad Hoc Community Committee on Drug Abuse. Ideally, this committee would have brought together agencies with overlapping programs, brought professional expertise to community association programs and made known to the public the nature of several questionable programs. The present Health and Community Services Council Community Drug Committee has evolved from that Ad Hoc Committee and periodically brings together over 36 government and private agencies in continuing efforts to coordinate their programs. Unfortunately, lack of authority and funding prevents this group from accomplishing its goal. The unhappy result is that the user and/or his concerned family is still confronted by the "Drug Abuse Problem Program" Problem, when he seeks direct help or information. The H. and C.S.C. published a Directory of Agencies. The agencies listed were those offering programs to the community. This was of some help, but its effectiveness was diluted by the council's lack of authority to publish evaluations of the programs. This experience demonstrates the urgency of the need for a coordinating Commission with authority. This urgency in turn makes the composition of the Commission of crucial importance. The Commission makeup as expressed in lines 12 through 19, Sect. 2, has evoked criticism by many private sector agencies, especially those working "on the street" in daily contact with substance users. There is a strong feeling that the stipulation of *"establishment"* members without specific legislative direction for representation of the young people would bar success of the Commission's coordinating attempts from the onset. Agencies with daily contact with individual members of the community feel that lines 17-19, reading "at least one young person, who is familiar with the drug problem among the youths of the State," is especially inadequate. Community acceptance, cooperation from users, and cooperation from private agencies are essential for the Commission's success.

(1) The Pharmacy Association respectfully suggests that the legislature accept a list of individuals agreed upon by those member agencies of the Community Drug Committee that are non-government affiliated and directly involved in drug programs; and that the legislature recommend to the Governor that he select from this list at least five individuals as his appointees to the Commission.

The validity of this approach has been established at the national level through the experience of the American Pharmaceutical Association. As reported in a two-page article in the January 20, 1968, issue of *Business Week:* "60 disparate groups, ranging from doctors and druggists to women's clubs and Boy Scouts . . . (met) for the first time at the call of the Food and Drug Administration and the American Pharmaceutical Association . . . Unanimous support was given for a task force to lay the ground work for a national council to coordinate public information and education on drug abuse . . ."

This APhA sponsored conference resulted in the highly effective National Coordinating Council on Drug Abuse Information and Education.

(2) The Pharmacy Association suggests that an additional section under functions of the Commission be added to the bill to include: "The Commission would be responsible for reviewing and maintaining the list of dangerous substances contained in the Controlled Dangerous Substances Act."

The reasons for this additional function are eloquently spelled out in Recommendations 18, 19 and 20, pages 38 and 39, of the Report of the Advisory Committee to the Office of the Attorney General on the Uniform State Control Dangerous Substances Act.

(3) The Pharmacy Association strongly recommends legislative stipulation that the Governor appoint a representative of the pharmacy profession to the Commission.

In the words of the previously referred to Advisory Committee Report, page 37, "Decisions about the relative 'danger' of substances to be placed on a list require a broad spectrum of knowledge, experience and attitudes. It is essential to bring to bear pharmacologic, toxicologic, medical, chemical and other scientific expertise." Each practicing pharmacist has been formally educated in pharmacology, pharmacognosy, toxicology, medical therapeutics, and innumerable chemistries including quantitative and qualitative analyses, organic chemistry, biochemistry and others. In addition to his academic background, each practicing pharmacist by law must be intimately familiar with drug classification and distribution limitations. His experience accumulated day by day over years of practice has to be helpful in what to many is a new problem.

As the historical and legal custodians of dangerous substances the pharmacists of Hawaii are the group most directly affected by legislation involving dangerous substance scheduling. Representation on the Commission couldn't help but make the Commission's day to day administration more efficient.

Finally, the pharmacists of Hawaii are dissatisfied with their "limited success in their efforts to contribute to the community. The absence of a State College of Pharmacy with its reservoir of academic and administrative expertise, available in most states, partially explains this failure. Individual pharmacists' lack of self confidence is also a factor. I know from experience that we have much to contribute to the Commission and respectfully ask for the privilege of participation."

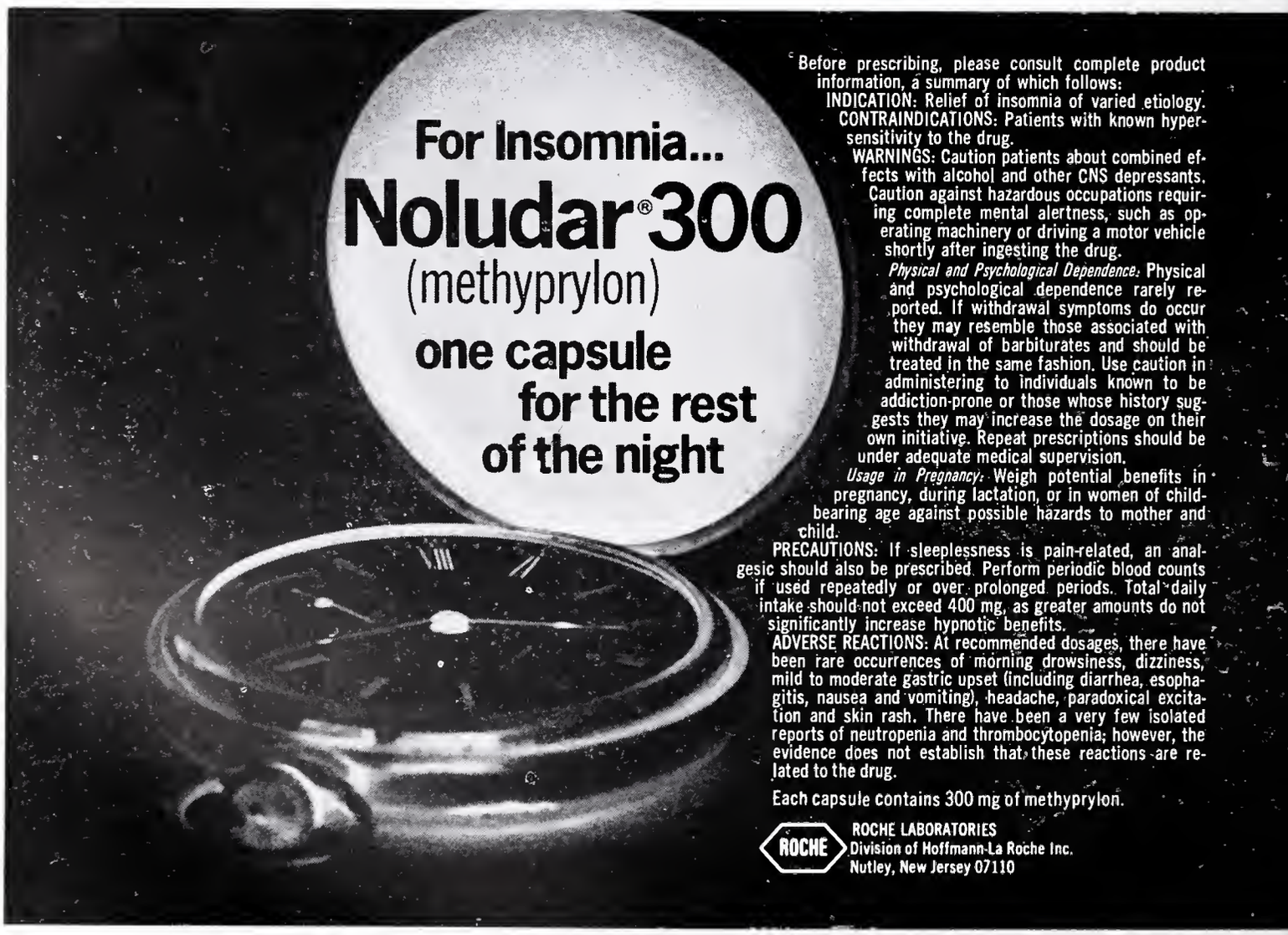
Hawaii Academy of General Practice

continued from 194

that even under the best of national health services, private contractual arrangements are often made on the side.

It should be apparent to legislators that any national health care plan that ignores human nature, that obviates the good aspects of a private contract between a patient and his doctor, will inevitably LESSEN the quality of medical care!

J. I. FREDERICK REPPUN, M.D.



Hawaii Medical Ass'n *continued from 207*

ACTION:

It was voted to recommend to the House of Delegates that this request be approved.

ACTION:

It was voted to approve the Treasurer's Report as amended.

UNFINISHED BUSINESS

Progress Report on Dr. Robert Worth's Proposal: Dr. Lowrey briefly reviewed Dr. Worth's proposal. He pointed out that two reports were referred to the Public Relations Committee and it was recommended that these reports be referred to the Board of Governor's for endorsement.

Progress on HMA Administrative Report: Mr. Thorson reported that Alexander Grant and Company has submitted its report relative to the staff merger, housing of the two organizations and committee adjustments. Council members were advised that this report is in the HMA office and is available for perusal.

Status of Health Maintenance Organizations (HMO's): The Council was informed that the concept of HMO's is being discussed considerably. It was noted that President Nixon delivered to the Congress on February 18, 1971, relative to this new approach. The HMO is based on four principles:

—It is an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of

—an agreed upon set of comprehensive health maintenance and treatment services for

—a voluntarily enrolled group of persons in a geographic area and

—is reimbursed through a pre-negotiated and fixed periodic payment by or on behalf of each person or family unit enrolled in the plan.

The Council was advised that a meeting has been scheduled with Mr. Paul Elwood for April 20 to discuss the HMO concept.

Progress Report on Peer Review: It was reported that Peer Review is being handled on the county level. The structure presented is not really definite and it is still questionable as to what Peer Review will encompass or where PSRO will fit in.

Public Relations Committee Opinion Survey: The Opinion Survey summary was circulated, reviewed and discussed.

ACTION:

It was voted to refer the survey to Mr. Murray Klutch of the California Medical Association to analyze the questions and the comments on the results.

Future Meetings with DSS relative to possible Foundation Program: The Council was informed that HMSA has been instructed by DSS to refuse claims not properly coded under the 1965 RVS.

ACTION:

It was voted to have the HMA Legal Counsel look into the legality of the situation presented.

NEW BUSINESS

Code of Cooperation: The News Media Committee met on several occasions with representatives of the news media and with other interested persons to update a Code to promote cooperative action among physicians, hospitals, and those who report medical news. Dr. John Brown made the presentation. The proposed draft was circulated, reviewed, discussed, and amended.

ACTION:

It was voted to recommend to the House of Delegates that the proposed Code of Cooperation, as amended, be approved.

School of Health Committee Request: The School Health Committee has planned a "Sports Medicine" workshop-seminar for April 30 and May 1, 1971. These dates were chosen so that school personnel from neighbor islands could also attend the meeting as the State Final Tournament in baseball and track is scheduled for these days.

A budget for the workshop-seminar was presented and the Committee is unable to meet the estimated budget at the present time. The committee requested the sum of $200 to carry out the workshop-seminar to assure the committee's success in this endeavor.

ACTION:

It was voted to approve the request for $200, if needed.

MISCELLANEOUS

John J. Lowrey, M.D., was given a standing ovation of thanks by the Council for his diligent work and untiring efforts for the year as President of the Hawaii Medical Association.

ADJOURNMENT

The meeting adjourned at 10:00 P.M.

R. VARIAN SLOAN, M.D.
Secretary

Ec-
on-
omy!

Dicarbosil®
ANTACID

Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Notes & News continued from 201

fewer and less pleomorphic occult prostatic carcinomas than Japanese men in Hawaii. This follows the pattern of immigrant European men as well for their second generation men have more prostatic carcinoma. **Quint Uy** was curious: "Is it due to increased sexual activity?"

Visiting Physicians

Unlike Wisconsin's **Fred Ansfield** who could be understood even by non-oncologists like us, Sloan Kettering's **Manuel Ochoa, Jr.** who was the RMP sponsored "tutor oncologist" here in February and March lectured to rapidly diminishing audiences perhaps because his lectures seemed to be geared primarily for fellow oncologists. Manuel, youngish, Mediterranean, brilliant and a staccato speaker was serious, unsmiling, and bored lecturing to the likes of us. We survived only two of his lectures, *i.e.* on lymphomas and leukemias and another on melanomata and lung cancer. We gathered therefrom that the average survival for acute leukemias is five years with therapy and two years without; that with chronic leukemias, there is no evidence that life is prolonged with treatment; that in chemotherapy of leukemias and lymphomas, total care is equally important, *e.g.* specific therapy for the disease and supportive care such as the use of allopurinal for the hyperuricemia; that the mode of delivery of agents is as important as the biochemical and biophysical effects; that the rationale of combination therapy is the elimination of all cells, that even if a single leukemic cell is left, relapse can occur; with more cells left, the greater the relapse . . . but unfortunately in attempting to eliminate that last leukemic cell, one is confronted with toxicity.

Professional Moves

In reviewing the migratory habits of Homo Sapiens Medicus in recent months, we conclude that they must be hibernating. One of our greatest losses will be that of **Harry Shirkey** who is leaving the Islands for Tulane Medical School where he will assume the chairmanship of the pediatrics department and the directorship of Tulane Services at Charity Hospital. Harry says, "I have mixed feelings, because I will be leaving a dedicated faculty, who if given the opportunity, will develop a very fine medical school here in Hawaii." Our fond Aloha to a great pediatrician, superb teacher, and dauntless innovator of many ongoing programs here. . . . We hope his departure will not in any way deter the fine quality residents who have been coming to Children's for training. A **Sherrell Hammar,** associate professor of pediatric medicine at the University of Washington School of Medicine, will be the new director of ambulatory services, and **Sharon Bintliff** will be coordinator of pediatric education. Former chief of staff **Henry Yim** will continue as acting medical director till the board finds a replacement for the medical directorship left vacant by Harry's resignation. . . .

In March, urologist **Anandom Hariharan** who was associated with **Patrick Cockett** in Kapaa, Kauai, islandhopped to join the Maui Medical Group. Child psychiatrist **Lars Slette** came from Arizona State Hospital in Phoenix to be staff psychiatrist for the Maui Mental Health Service. In April, **Herminio Mercado** of the Waianae Medical Clinic opened a Waipahu office and **Joseph Brock** relocated to 1481 South King St.

Elected, Honored and Appointed

We congratulate **Herb Chinn** who succeeded **John Lowrey** as president of the HMA. Among Herb's accomplishments are several years as HMA treasurer, Honolulu County president in 1966, physician Father of the Year in 1966, and father of six children. **William Iaconetti** of Maui was elected president-elect, **Tom Frissell,** treasurer, **Varian Sloan,** secretary, **George Mills,** AMA delegate, and **Ted Tomita,** alternate delegate. Councillors elected were **William Dang** and **H. William Goebert, Jr.** from Honolulu, **Peter Kim** from Kauai, and **Sakae Uehara** from Maui.

On the political front, the Governor appointed **Mor James McCarthy** to the Board of Medical Examiners, **Richard Mamiya** to the Board of Health and **Richard**

WILFRED HITOSHI KURASHIGE, M.D.
1911-1971

Dr. Wilfred Hitoshi Kurashige was stricken suddenly and passed away the morning of January 5, 1971. He had been in failing health the past year and had been doing part time practice the past few months.

Born in Holualoa, Kona, Hawaii, he graduated from the Konawaena High School in 1930 and received his BA degree from the University of Hawaii in 1934. He attended Northwestern University Medical School, from which he graduated in 1938, and took his internship at the Cook County Hospital in Chicago, Ill.

From 1943 through 1950 Dr. Kurashige was in private practice in Naalehu, Kona and also acted as plantation physician for the Hutchinson Sugar Company. In 1950 he took a dermatology residency at the Bellevue Hospital in New York, where he spent two years, and did one year at the New York Postgraduate Medical School in 1953, studying dermatology and cancer.

He returned to Hawaii and practiced dermatology at 181 S. Kukui Street until his death on January 5, 1971.

Dr. Kurashige was a diplomate of the National Board of Medical Examiners (1940) and a diplomate of the American Board of Dermatology and Syphilology (1955).

He was a member of the Honolulu County Medical Society; Hawaii Medical Association; Hawaii Dermatological Society; American Academy of Dermatology. International Society of Tropical Dermatology; and the Kona Club; and as an ardent bowler, was on the Board of Directors of the Oahu Bowling Association.

Dr. Kurashige is survived by his wife Daisy and two daughters, Elsie (Mrs. Tipton) and Christine.

TORU NISHIGAYA, M.D.

Ando to the Education Commission of the States.

Neal Winn was awarded the A. H. Robins award and the title of Community Physician of the Year for his work with the Waikiki Drug Clinic. Besides doing private practice, Neal is also director of the methadone maintenance program at Queen's Medical Center and coordinator of the outpatient clinic at Kapiolani Hospital. Neal, who apparently sees his wife on Saturday afternoons by appointment only, said, "I should thank my wife for putting up with me for the last two years. I've been putting in about 120 hours a week."

Cal Sia was re-elected chairman of the board of directors of the Variety Club School; **Sam Allison** was elected a director of the Bank of Hawaii; **James Erickson** was appointed to the Committee on Mental Health of the American Academy of General Practice; **Sam Wallis** of Kauai was elected HMSA secretary and **Paul Tamura** and **John Watson** elected HMSA directors; and **David Fergnsson** was granted a fellowship in the American College of Cardiology.

Joe Strode was honored at a retirement dinner at the Royal Hawaiian, celebrating both his 80th birthday and 50th year with the Straub Clinic. Before presiding over the cake cutting ceremony, he carefully checked with his colleagues whether he was insured against malpractice charges before he lifted the knife. **Harry Arnold** commented in the January-March issue of "Straub Clinic Proceedings" that "His presence, his firm, but gracious manner as a presiding officer, his unfailing recognition and praise for achievement by young doctors, his admonitions to partners who seemed laggard in any respect are all going to be sorely missed."

Catalino Cachero's 19th Hole Repertoire

"Father, I can't help but marvel at the way you keep from swearing on the golf course." "Yes, but where I spit, grass never grows again."

"You ought to play golf for your health." "But Doc, I do already." "Then, maybe you ought to stop."

In the St. Francis Hospital emergency room, **Bill Dang** was removing a golf ball accidentally driven down the throat of a greenskeeper. The nurse noticed **K. S. Tom** pacing outside. "Relative?" she asked. "Nah, that's my ball."

"Why so late?" "It's Sunday and I tossed a coin between church and golf." "What happened?" "Had to toss 15 times."

"Just got a new set of clubs for my wife." "Good trade?"

Gabe Ma rejoined the group after playing a difficult lie at the bottom of a crevasse. "How many?" asked his opponent **Dick Ho.** "Three." "Three! But I heard six!" "Three were echoes."

"I don't like the way you cheat on your score card." "Don't know any other way."

Selected Jokes by Tom Thorson

"Mrs. O'Shaunessay, we are sorry to report that your husband Joe drowned in a vat of beer." "Did he die happy?" "He must have. He had to climb out of the vat twice to go to the bathroom."

The town council of this farming town turned down a request for a *registered* pharmacist because it felt there was nothing to breed it to. . . .

UGDP Backlash

In the wake of the UGDP uproar, **Willard Miyahira,** back in February, reported at a Queen's conference that the American Diabetic Association recommends as follows: "Any adult onset diabetic, treat with diet alone. . . . If control is not adequate, then use insulin. . . . When insulin is not feasible, then use oral hypoglycemic agents. . . ." Someone asked, "What do you do with your own patients?" Willard: "I still treat with oral hypoglycemic agents." Medical director **Jim Orbinson:** "After seeing this, I'm rather dubious about their conclusions."

Then in early April, along came Diabenese advocate **Edgar Haunz** of North Dakota, understandably and gingerly waited on by local Pfizer representatives. This stocky, broad foreheaded (who was formerly called "Curly"), gravel voiced, convincing speaker with horn rimmed glasses spoke on "Diabetes—A Diagnostic Challenge and Therapeutic Dilemma." We gathered the following:

re UGDP study: Something good came out of something bad. . . . Diabetes is one of the worst treated conditions in the U.S. . . . But I still think we have come a long way in the treatment of diabetes.
re GTT curves: Do not use this screening test as diagnostic without being circumspect. . . .
re misdiagnosed diabetes: This is a highly charged malpractice situation. I generally say, "I did not say you did not have diabetes then. . . . You should go to church every Sunday and thank God you don't have it now. . . ."
re "Afternoon diabetes": This is secondary to the diurnal curve esp. with post prandial blood sugars. . . .
re the FDA's attitude: The FDA has been very ambivalent regarding the situation. It throws the burden on the physician's lap. . . . They take a seven million dollar study and take such an attitude and still leave the drug (Orinase) on the market. . . . They take the stand that all oral agents are to be avoided, but do not even mention DBI. . . .

Timely aphorisms:

We should abolish intercourse to prevent cervical cancer. . . .
We should remove all breasts to prevent breast cancer. . . .

GENERAL PRACTITIONERS NEEDED

FOR TEMPORARY, FULL OR PART TIME EMPLOYMENT

at HAWAII STATE HOSPITAL

Located in Kaneohe

PLEASE CONTACT DR. ALDON ROAT, *Medical Administrator*

For Additional Information Telephone 247-2191

We should abolish oral agents from one million diabetics and use insulin (Haunz).

re Phenformin: Phenformin should be taken off the market. . . . It's like cyanide. . . . Do not use Phenformin to stabilize brittle diabetes. . . . We should use Phenformin with a great deal of circumspection. . . .
re obese diabetics: The common denominator for all such diabetics is "Plain Common Fat."
re Chlorpropamide: We have used Chlorpropamide for 11 years now. . . . We add Phenformin as necessary. . . .

In summary, **Ed Haunz** commented: "The great object lesson of this controversy is that we are dealing with very potent drugs. . . ."

Then to the HMA Convention at the end of April came **Peter Forsham.** This thin haired, medium built, bespectacled, suave, humorous, master speaker reinforced his talk with excellent slides and a constantly gesticulating **R** hand.

When **Kenneth Gardner** introduced him with: "We have reviewed all the conflicting reports (since the controversial UGDP studies). . . . So with that, Dr. Forsham, what the heck do we do?"

Peter was quite sympathetic: "I'm quite certain that of all the diseases treated in the U.S., diabetes is probably treated the worst way. . . . I know how you feel about treating diabetics once a month with all their assorted aches and pains and you would prefer a clear cut disease like a duodenal ulcer. . . ." Herein are some Forsham quotes:

"The long acting insulins (*e.g.* protamine zinc insulin) probably did the greatest disservice to diabetes. . . . This is not physiological. Nature has provided that whenever glucose comes in, there should be insulin." (He advocates the return to regular insulin at four injections a day for long term survival and related the story of a diabetic lawyer who married a nurse. The lawyer continued his regular insulin over 48 years in spite of efforts to convert him to long acting insulin and does not have a single microaneurysm in his eyes.)

"The number one therapy for obese diabetics is weight loss. In obesity, insulin is not as effective. There is actually an enormous amount of insulin around. . . ."

"For the fat diabetic, Phenformin is the drug of choice. It prevents absorption of glucose, rests the islets, and slows down gluconeogenesis. Nausea, which is a side effect makes it easier to lose."

"For the adult diabetic with a high glucose curve and low insulin levels, we recommend the sulfonureas."

Forsham regimen: 1. Diet and exercise. 2. Fat diabetic: DBI. 3. Thin diabetic: Small amounts of sulfonureas with two hour pp every two months. If not down, then other therapy.

"In summary, in spite of the UGDP study that treatment of blood sugar shows no advantage in vascular complications, with the older diabetic, diet is more important than ever. In a fat diabetic, use DBI. In a thin diabetic, use sulfonureas. We must change the American diet which is 40% fat and huge amounts of carbohydrates and cut down on the use of saturated fats. For long term survival, we should cut down sugar in normal people and in diabetics."

Sportsmen?

Our 11 handicapper **Hide Oshiro** and his 10 handicap partner were playing 7 handicapper **Richard Henry** (visiting BioScience Lab director) and congenial 22 handicapper **Art Salcedo.** Said Hide, our brash competitor, at the first tee of the Makaha Golf Course (even though his team had more than a slight edge), "We'll play you even. . . ." Said Japanese scholar Dick Henry to Hide Oshiro after he and Art were badly trounced in an obviously lopsided match, in no uncertain terms, "DOROBŌ." (Japanese for "thief") during the post tournament festivities. . . .

Bill Dang overheard the following conversation between **John Takamura,** chief of anesthesia at Queen's, and **Calvin Kam,** newly elected chief of neurosurgery at Queen's. John: "I should have warned you about accepting the position." Calvin: "Why?" John: "They do not respect you when your golf handicap is high." (Axiom: It behooves us to improve our golf handicaps before accepting positions of trust.)

Conference Humor

A 53 year old man with Ca of the lung and a R+ neck mass developed a superior vena caval syndrome over a weekend and **Ed Quinlan,** Kuakini radiotherapist, was being chided. . . . **Quint Uy:** "Unfortunately Ed is not around on weekends. . . . I recommend a shot of Cytoxin or nitrogen mustard for relief on weekends. . . ." The possibility of radiation pericarditis was brought up maliciously. . . . Ed defended his high voltage machines: "We try to scoot around the heart to prevent pericarditis." **Noboru Oishi** pursued the matter: There may be a delayed onset, even up to six months or later." Pathologist **Grant Stemmerman** added fuel to the fire: "We had a case of post radiation MI recently." Ed put up a valiant defense: "We even cure MI's with irradiation."

Visiting pediatrics professor, **John Kenward** (U of Chicago professor of psychiatry and pediatrics) was discussing death and autopsy requests by the house staff. "I think it rather ghoulish to ask for an autopsy after death. This, however, depends on the relationship with the parents. My own internship experience was 100%, which meant that either I had good rapport with parents or my patients did not die." Pediatrician **John Peyton** confessed, "It seems to me that internists take it lightly. I'm not sure I did not go into pediatrics to avoid this situation."

"A 55 year old Hawaiian man was admitted for evalua-

HONOLULU, HAWAII

44 Physician multispecialty group in downtown Honolulu wishes additional Board eligible or Board certified physicians in Dermatology and the following subspecialists of Internal Medicine: Nephrology, Allergy, Hematology, Endocrinology, and Pulmonary Disease.

Excellent opportunities for growth.

New facility to be completed in 1972. Partnership after one year. Excellent fringe benefits.

Teaching opportunities available.

Clinic located immediately adjacent to 400 bed general hospital.

tion of an 18 month weight loss of 29 lbs. and a cardiac arrhythmia." At the Queen's clinicopathological conference, the panel of experts of **Doug Bell, Allan Leong** and **Robert Bart** offered possible causes for the patient's demise ranging from hypoadrenalism to subarachnoid hemorrhage to myocardial infarction. **Jim Orbinson** was rapturous, "That's the fun of this situation. You get to stick your neck out and get it chopped off," and guessed that the angiogram may have contributed to the rapid demise. The pathologist's report revealed complete destruction of the adrenal glands and it was brought out that formerly 90% of Addison's was acid fast and the rest metastatic Ca, but recent statistics show that 50% are idiopathic and probably due to some autoimmune reaction and involving only the cortex. Our pedantic editor, **Harry Arnold, Jr.,** was less impressed with these findings than with the use of "male" in the protocol. "I wish to make my annual comment regarding the terms 'male' and 'female.' 'Man' and 'woman' are shorter and more precise. . . . 'A 55 year old male' can be a superannuated horse or a?..... breadfruit."

Queen's Medical Center Dialogue On the Beverly Paine Report

Commenting on the Makaha Seminar, **Jim Orbinson** admitted, "Our initial reaction ranged from outrageous disbelief to stunned silence. . . . But we should make a sincere effort to improve. . . ."

Warned **Unoji Goto,** "It (the report) may be used by third party interests such as insurance carriers or the government."

Jim reported that the three most frequent overstays as per criteria were CHD, bronchitis, and chronic GU infections.

Max Botticelli was objective: "We have bloated feelings about ourselves, that we're doing a good job." Max reported that the RN's griped about poor communication with physicians, that they did not feel part of the physician-nurse team, that they had problems with X-ray and the Lab, and that they felt that their stature had deteriorated. . . . Jim was concerned: "If the staff (*i.e.* the RN's) doesn't have a good opinion of the quality of care, this may rub off on patients." Max: "We went over this for hours. . . . But the relationship between the medical staff and nurses is poor. . . . It is difficult to get nurses to say anything because nurses are not accustomed to talking back. . . ." Unoji was perspicacious: "Rather than looking at the punitive side, we are looking into the educational side." Max: "We went through mental gymnastics. We are all involved in poor statistics. We do a better job than the statistics prove." Someone thought patients should be canvassed. **Harry Arnold** pointed out, "Patients are not judges of medical care. They have an emotional reaction." Unoji: "We recognize our problems. It's tough to go to Makaha and eat crow. . . ." and brought out the truism that "time" and "fatigue" are factors involved. . . .

Annual Banquet at the Ilikai

Newly inaugurated HMA president **Herb Chinn** praised outgoing president **John Lowrey** for his quiet dedication to duty, and there was a standing ovation for John during the presentation of the traditional plaque. John reciprocated with the traditional presentation of the "Broken Cane Award." John, looking relieved, said, "Now that all the official business is over and I can relax, I've been looking forward to making this presentation. . . . I checked into the history of the "Broken Cane" and learned that Dr. Spencer had started the tradi-

For World Travelers WHO HAVE BEEN EVERYWHERE



HAWAII CONDOMINIUM RENTALS: Enjoy a quiet week or month of just plain beauty, swimming and hiking in tropical Hawaii. Golf and deep sea fishing available. HANALEI COLONY RESORT on the North Shore of Kauai, Hawaii's Garden Island. Nestled in giant Australian pines, right on the pounding surf of the Pacific, along with the Anchorage Restaurant with out-of-this-world meals. No night life; just the tropical moon. Two large bedrooms accommodate four. Complete kitchen with refrigerator, washer/dryer.

For a week or month of beautiful quiet, tropical living, write:

Hanalei Colony Resort

For reservations call collect Kauai 826-6235

tion and Dr. Hill was once presented with a confederate cap. . . . I asked **Richard Chun** for ideas on a Chinese good luck charm and Richard replied, "Get something red. . . ." So John had the traditional broken cane properly wrapped in "Chinese Red" wrapping paper which he unwrapped and gingerly presented to Herb. Then John recalled all the happy council meetings held at the Red Rooster and presented Herb with an uncooked, but defeathered whole chicken with a red ribbon around its neck. He also gave Herb a "Superman Red Cap" so that Herb will become the superman needed to put the budget in the "black" (this being the connotation of the black portion of the broken cane). John also added, "Just in case the budget is not in the black by the end of the year, here are a couple of dice on the cane." Also attached to the cane was a red rabbit's foot for extra good luck and a pack of fire crackers to fire when Herb's term was up.

Terrance Rogers, acting dean of the Medical School, in accepting the proceeds of the AMA-ERF fund, punned, "We hope with Herb's leadership, organized medicine will lead with its *Chinn*. . . ."

Hugh Lytle, retired PR counsel, presented *Star-Bulletin* reporter Murry Engel (for her State Hospital series) with the annual HMA medical writing award and a spanking new perpetual award (the old sterling silver trophy was lost during the year and the *Advertiser* replaced the original. . . . Interesting note: the original $40 sterling silver bowl had inflated to $400 which the *Advertiser* willingly absorbed). The 2nd place award went to Robyn Rickard. For the first time, there were entries in the Educational Division and two students, Gladys Liu and Sydney Burrel were co-winners for their joint paper on Australian Antigen which had been published in the HAWAII MEDICAL JOURNAL. *Star-Bulletin's* Bud Smyser was given a special award for his excellent series on "Death." **Neal Winn** received the A. H. Robins award (for community service) in recognition for his many community activities, including the Waikiki Drug Clinic.

Master story teller **John Smith** dressed in a bunny costume kept the audience in stitches with his repertoire of jokes. We tried to record a few. (Excuse us, John, if we don't get them exactly right.)

"What is the difference between a spinster and an old maid. The old maid never got married, but the spinster never got married or anything. . . ."

"Man at the bar was asked by a friend: 'I thought your doc limited you to one drink per day?' 'Yeah, this drink is for June 1, 1988. . . ."

"A doctor treated a rich Texan and the grateful patient insisted he wanted to do something for the doctor. . . . 'Oh well, why don't you get me a couple of golf clubs.' Several months later, the Texan called him and apologized, 'Sorry it took so long. I finally got you the two golf clubs, but only one comes with a swimming pool."

"An Indian couldn't tell the difference between heads and tails . . . and he got some of the darndest scalps. . . ."

Physicians Speak Up

During a February Episcopal Clergy's "Conference on the Professions," critic **Robert Worth** of the U of H School of Public Health cautioned the organization "not to go the AMA route. By and large, it is a totally unresponsive organization today, particularly on the state and national levels. This seems to happen to organizations with time."

During a January meeting of representatives of the "hip" and "straight" communities of Kona (where apparently 1,400 to 1,600 'long hairs' are living), Kona physician **Wilmot Boone** objected to a proposed program for solving the housing and medical problems on grounds that "It would only attract more transient youths to Kona. . . . Why should we let these people in who are absolutely useless?"

continued page 217

Keep a Healthy Practice with PMMS

PMMS—a comprehensive computerized Professional Medical Management System designed specifically for physician's offices incorporating:

- **AUTOMATED PATIENT BILLING**
- **AGED ACCOUNTS RECEIVABLE REPORTING**
- **AUTOMATED INSURANCE CLAIM FORM PREPARATION**
- **RVS PRACTICE ANALYSIS REPORTS**
- **MANAGEMENT CONTROLS**
- **DELINQUENT COLLECTION PROCEDURES**

Designed and operated locally by Control Data Corporation in conjunction with the Bureau of Medical Economics, a subsidiary of the Honolulu County Medical Society.

BUREAU OF MEDICAL ECONOMICS LTD.
111 N. King Street
Honolulu, Hawaii 96817
Phone: 536-9691

CONTROL DATA CORPORATION HAWAII DATA CENTER
2828 Paa Street
Honolulu, Hawaii 96819
Phone: 833-7600

when an unnerving experience compounds the pain



the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, and frustration. No doubt these psychic factors actually increased her perception of pain. Surely the last thing she needs is an analgesic containing caffeine. The logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

Phenaphen®

with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming). **Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.
A. H. Robins Company, Richmond, Va.

A·H·ROBINS



'head clear upon arising'

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

prescribing information appears on next page

Dimetapp® Extentabs

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company
Richmond, Va. 23220

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Our editor, **Harry Arnold, Jr.**, rose to the defense of **Walt Quisenberry** who was being "shafted pretty fiercely" by a newspaper cartoonist because Walt had pointed out that our water purity standards in Hawaii may be too high. Harry remarks that our late Max Levine who knew more about the bacteriological standards of water purity than any other American scientist had frequently told him that our standards here were unrealistically and unnecessarily high. "Nobody is in favor of pollution, but there is no need to create it by definition where it doesn't necessarily exist. And no need, either, to poke fun at a competent and well-informed public servant for making a perfectly proper statement about something well within his kuleana." (Hear! hear!)

By contrast, at a February air quality standards workshop at Princess Kaiulani, **Phil Jones**, president of the Hawaii Thoracic Society, suggested that the Health Department establish air quality standards with a "zero" level. Phil feels that next to cigarettes, automobiles are the worst source. He suggested that we limit the number of vehicles by raising the registration fee ($5,000 for the first car, $10,000 for the second, and $15,000 for the third) and that auto manufacturers be pressured into producing vehicles other than those with internal combustion engines. (Knowing Phil, he's joking, of course, as usual, we hope. . . .)

During a January symposium on Human Sexuality at the U of H, plastic surgeon **Bob Flowers** reported that flat-chested women were coming in "by droves" to have their bust-lines expanded artificially. Bob says surgery is popular because "flat-chested women are almost castrated individuals psychologically in this society," and that following such surgery, these women "no longer feel neuter." "They begin to ooze femininity. They smile more femininely. They talk more femininely. They feel more feminine." Bob says that bosom-building costs "less than a new car" or somewhat under $1,000 here (per breast?).

The Catholic-Action Group (of 40 persons) delivered a bottle of blood and tax forms smeared with red ink to the Hawaii district office of the Internal Revenue Service as a symbolic gesture of a Good Friday vigil and protest. Spokesman **Fred Dodge** was quoted as saying, "This is definitely a Good Friday service. It very appropriately combines service and action. Liturgy is action. This is a religious service to me. Today's crucifixion is in Vietnam."

When the newspapers headlined, "Major Cancer Breakthrough," based on reports from the American Cancer Society convention, **Scott Halstead** was understandably perturbed. "I should hope that your editorial staff would realize that there are many people afflicted with cancer who search the news media anxiously day after day for new cancer 'cures.' To headline a research finding made in a test tube culture which has not yet been tried on animals, let alone humans, may cruelly raise false hopes. . . . There is as yet no chemical cure for any known cancer. Those who provide information to the public have a sacred trust. In Sunday's front page headlines, your editorial staff gave little evidence they understand the limits to that trust."

John Chalmers points out that as a local boy himself, he is against "the so-called protective umbrella of the 'local boy' syndrome. I have always felt that this residency requirement was an indication of the thinking of a great many people that we could not stand up against the competition of people coming into the State, and therefore some form of protection 'for our own' should prevail. This type of thinking, to my mind, is indicative of what appears to be a massive inferiority complex and if not that, at least some indication of tunnel vision. I have always felt that this residency requirement is unconstitutional. . . . Competition is what made our country great in every field of endeavor, and the need to be as good as (or better than) any malihinis, could serve only to improve the quality of medical care in this State."

We note that whereas most Honolulu boxing fans were overwhelmingly favoring Joe Frazier to beat Cassius Clay, our sportsman-physician-promoter **Richard You** blandly predicted that "Clay will beat Frazier."

continued page 218

NEED OFFICE SPACE WITH AMPLE PARKING?

- A prestige medically oriented complex will be soon under construction on a portion of the Moiliili Community Center on South King Street.
- Applications and reservation for office space now being entertained. Details and building plans available.

Leasing Agent: Pacific Land Company
Phone: 949-2975
Developer: Dr. Shigeo Natori
Architect: Tagawa, Yamachi, A.I.A. & Associates, Inc.

Ira Hirschy, chief of the Communicable Disease Division, feels that the prevalence of VD in the Islands is exceeded only by respiratory illnesses and strep throat. He says that reported gonorrhea has increased from 336 in 1966 to 1,060 last year, and that there are indications that it is spreading among high school students. Ira feels the increase is "mainly because the behavior of people has become more lax now. Evidently, there is much less concern about promiscuity than in the past." Another factor is the increased use of birth control pills and a decrease in the use of prophylactics which used to be an effective way of preventing gonorrhea.

William Busse's daffynition of a Portuguese place setting—"Silva ware."

When the Refuse Department conducted a month's trial of plastic rubbish bags in Waianae, **Mary Glover** was unhappy: "The black, plastic rubbish bags which have been foisted on the Waianae Coast for the month of February are anything but popular or satisfactory. This letter is to correct any mistaken impressions that the silence you hear from this area represents enthusiasm. Instead, it represents semi-exhausted resignation. We will be greatly relieved when the month is pau. Intelligence in our area is not confined to the human. Enough of our dogs are intelligent enough to be able to achieve fast and direct retrieval of any contents which smells interesting to them. . . ." (There is more to this humorous letter to the editor, but we are pressed for space.)

When a woman delivered a baby alone in a jetliner lavatory without anyone aware of it and left the baby in a wastebasket which was fortunately found and cared for in a local hospital, some physicians were asked to comment.

Bob Hunter: "The amount of racket that is made (by the mother) depends on the ancestry. However, I don't think it happened that easily. She did a good job of pulling the wool over everybody's eyes."

Richard Sakimoto: "I think childbirth usually isn't as difficult as haoles make it. Those Hollywood movies dramatize the agonizing facial expressions as if it were a 50-50 chance of the mother's dying. For millions of years, our ancestors gave birth with no difficulty whatsoever. If you let nature take its course, there are usually few complications."

Recently some magazines and newspapers have been depicting tattoos on women as being glamorous, exciting and even "sexy." Dermatologist **Norman Goldstein** was concerned: "Tattoos are not as innocuous as implied. . . . In 1961, after an epidemic of serum hepatitis in New York, tattoo parlors were outlawed. . . . All sorts of infections have been transmitted by tattoo artists' needles over the years: leprosy, warts, tuberculosis, impetigo, and even syphilis. Some tattoos can even cause a severe sun allergy in the red pigmented areas! . . . Let us hope it does not come 'in' for our women."

Jim Erickson is an avowed proponent of legalizing marijuana. At legislative hearings in February, he told legislators that marijuana is less harmful than alcohol and tobacco, and he would rather see his patients use marijuana than alcohol. During the last 10 years, he has studied about 6,000 people who have used marijuana and found only one with a medical problem and that was a 13 year old girl who was punched in the nose by an irate mother. Jim also is a vocal environmentalist. He feels that the Hawaii Visitors Bureau should support the environmental movement. "It is not hysterical or otherwise irresponsible action to talk about imminent and actual dangers to the environment. The air and water

INSURANCE EXCLUSIVELY

Brainard & Black, Ltd.

1712 S. King Street, Honolulu 96814

Telephone: 949-0031

"Small enough to know you,
Large enough to serve you"

ZIMMER
MEDICAL INDUSTRIES, LTD.
MILTEX

ORTHOPEDIC EQUIPMENT & SURGICAL INSTRUMENT SPECIALISTS

Don Bloedon
John McCready

Phone 949-0396
949 McCully Street, Room 11
Honolulu, HI 96814

pollution crises we face are real, growing, and promise the virtual destruction of the visitor industry if action is not taken soon."

Doctors in Print

Malacologist-physician **Clarence "Pat" Burgess** has published "The Living Cowries" which is available for $30 a copy. **Harry Shirkey** is the author of a chapter on the physician's role in helping a family accept a child's death in the book, "Should Doctors Play God?" **Bill Moore, Jr.** answers letters of inquiry in Today's Health in the Growing Pains column.

Announcements

THE TWELFTH CONGRESS OF THE PAN-PACIFIC SURGICAL ASSOCIATION

Concurrent meetings will be held in: Anesthesiology, Colon & Anorectal Surgery, General surgery, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-cardiovascular, and Urology. Date: February 26 to March 4, 1972.* Place: Hilton Hawaiian Village Hotel, Honolulu, Hawaii. For details, write: Cesar B. DeJesus, M.D., Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

*Please note change in date from March 3 to March 4, 1972.

SECOND ANNUAL SEMINAR IN GENERAL SURGERY

The seminar, given in an informal atmosphere by a distinguished faculty, will concern itself in areas of management of trauma, vascular disease, breast disease and problems of the biliary tract. It should appeal to practicing physicians and surgeons, residents and recent graduates of residency programs. Date: July 22 and 23, 1971. Place: Colby College, Waterville, Maine. For further information, write: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.

31ST ANNUAL AMA CONGRESS ON OCCUPATIONAL HEALTH

The Congress will be held at Jackson Lake Lodge in Grand Teton National Park, Wyoming, August 29-30, 1971. For further information, write: Louis R. Skiera, Assistant Director, Division of Scientific Activities, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

CONTINUING MEDICAL EDUCATION PROGRAM

The program entitled "Coronary Artery Disease and Cardiac Arrhythmias" will be held on November 19, 20 and 21, 1971 at the Surfrider Hotel, Honolulu. Cosponsors: The American College of Cardiology in cooperation with the University of Hawaii School of Medicine. For further information, write: Miss Mary Anne McInerny, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 949-3288

MEDICAL PLACEMENT BUREAU
and
NURSES' REGISTRY

24 Hour Service

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

1415 Kalakaua Avenue **Suite 210**
Phone 949-1237

Dial
537-5353
for
the finest printing service
in the state

star-bulletin printing company
420 WARD AVENUE HONOLULU, HAWAII 96814

County Society News *continued from 205*

Approximately 168 members attended the April 6 meeting. New members Dr. Gene Doo and Dr. Allan Izumi were introduced to the membership.

Dr. Leonard Scherlis, Professor of Medicine and Chief, Division of Cardiology, University of Maryland School of Medicine, discussed new procedures in cardiopulmonary resuscitation. Dr. Scherlis is the recipient of the American Heart Association's Award of Merit for 1971.

A unanimous vote was cast to elect Dr. William F. Moore, Jr. to the position of Society Treasurer, replacing Dr. Elmer Johnson who had resigned.

The chair announced the untimely death of Mr. William Bowman. He had recently been hired to head up the Foundation for Medical Care's new self insurance program.

The membership was presented with the Board of Governors' recommendation approving an increase in the conversion factor of the Foundation for Medical Care to an equivalent of 7.0 of the 1965 RVS. The Board of Governors states that if the doctors are using the 1970 RVS, they should use a conversion factor for each section that is the equivalent of 7.0 on the 1965 RVS. Following the discussion, it was voted that the recommendation of the Board of Governors be approved.

It was reported that the Argonaut Insurance Company is accepting applications and will continue to accept applicants in their professional liability insurance program under the auspices of the Hawaii Medical Association.

Dr. William Kirker made a brief report on the progress being made in his Africare project. He stated that they needed more doctors as well as more money. He thanked the physicians for their help in the past and hoped they would continue with their support in the future.

Maui

The April 20 meeting was held at Heinz Restaurant with 18 members present.

Dr. Sowers stated that the Argonaut Insurance Agency was interested in having the local Society set up a committee for review of applicants and possible litigation cases. Dr. McCollum reported on the Maui County Medical Society proposal for the Adjudication Committee. The program was very extensive and was well received by the members. Essentially lawyers of the plaintiff may submit the claim to the committee if they agree to arbitration and that the findings of the committee will be confidential and the members would not be subpoenaed to testify. Dr. Moran moved that Dr. McCollum should be thanked for the amount of work involved in establishing this committee. Motion was passed unanimously. Dr. Moran then moved that the Adjudication Committee be delegated the authority to review the applicants for Argonaut Insurance and to review any possible malpractice cases arising with the Argonaut members.

Dr. Sowers reported that the Zendo Mission in Haiku was establishing a first aid center for primary treatment of patients. Dr. Uehara pointed out that they may be practicing medicine without a license, and that we should so advise them that they should keep their treatment at a first aid level. Dr. Sowers stated that a letter will be sent to that effect.

Dr. Uehara then reported on the Health Maintenance Organization. They are interested in establishing prepaid capitation plans and the opinion was that if the cost of health plans goes down that quality of medical care will also go down. However at this time HEW was concerned primarily with cost of health care.

Dr. Sowers brought before the members of the Society the matters for the House of Delegates of the forthcoming state medical meeting. The nominating com-

mittee has submitted Dr. William Iaconetti as President-elect. Dr. Uehara was elected unanimously to fill Dr. Iaconetti's position of Councilor from Maui.

The Publicity Code for Physicians was reviewed. It was pointed out that there were certain elements peculiar to Maui County that should be included in the Code as the information articles concerning newly arrived physicians.

Dr. Sowers then introduced a resolution for the House of Delegates for approval of Doctors of Osteopathy as members of the Hawaii Medical Association. It was suggested that the Resolution be changed to state certified O.D.'s The resolution was then moved and passed by the Society.

University of Hawaii *continued from 196*

Izumi, Arnold Jr., Sunahara, and **Palmer;** ophthalmologists **P. Chee, Sugiki, R. Wong, H. Pang, Hayashida, J. Corboy, J. Thompson, M. Ing, O. Pinkerton, Holmes, T. Maeda Jr.,** and **Moffat;** otolaryngologists **Watson, Joseph, Doo, G. Chun, H. Oshiro, T. Hata, L. Pang, Newbill, Kaku,** and **W. Young,** and internists **R. Ho, T. Lau, Wakai, Ball, D. Seto, Beddow, Ogata, Nordyke, G. Lewis,** and **Berk.** Many other physicians in other specialties have fulfilled roles as tutors in this course in the past few weeks.

In anatomy, surgeons from many specialties are in the dissection room to teach *applied* anatomy realistically. Coordinators for this program include **Drs. Batkin, Faulkner, L. Gordon, F. McDowell, O. Pinkerton, Mason, Odom, L. Q. Pang, Simmons,** and **B. Tom,** but many other surgeons participate.

A number of second-year students attended an elective in surgery during the past semester. Practicing surgeons who conducted seminars included **Drs. Kokame, W. Chang, C. Lum, E. Izawa, E. Jim, J. McNamara, L. Gordon, V. Mori, Oda, Mamiya, Batkin, Shim,** and **Judd,** and anesthesiologist **Pearson.** The coordinator was **Dr. P. Hong.**

C. S. Judd, Jr., M.D.
P-W Hong, M.D.

Slants and Angles *continued from 195*

ceives are in hot blood, and if they do not hurt anymore than the wounds a man receives in hot blood they cannot hurt much. But as long as man is regarded as having an immortal soul, and doctors will keep him alive through times when death would seem the greatest gift one man could give another, then the horses and the bulls will seem well taken care of and man to run the greatest risk."

W. Philip Jones, M.D.

Call Us for
OPHTHALMIC INSTRUMENTS

GUILD OPTICIANS
OPTICAL DISPENSERS
of Hawaii, Inc.

532 PROFESSIONAL CENTER BLDG.
1481 SO. KING STREET — 955-6314

1133 BISHOP STREET
HONOLULU, HAWAII — 537-6570

1441 KAPIOLANI BLVD., SUITE 312
HONOLULU, HAWAII — 949-4795

103 PROFESSIONAL CENTER BLDG.
30 AULIKE STREET
KAILUA, HAWAII — 261-6030

Complete Contact Lens Service Available

Equipment Distributors for:

CARL ZEISS, INC., BAUSCH & LOMB, AMERICAN OPTICAL CO., SHURON, TITMUS, RELIANCE, WELCH ALLYN, KEELER AND LAWTON INSTRUMENTS.

it's the real thing

Enjoy Coca-Cola Trade-mark ®

COCA–COLA BOTTLING COMPANY
OF HONOLULU, INC.

MAY WE HELP YOU

TO HELP YOUR PATIENTS?

Complete Line – Orthopedic Supports
Artificial Limbs – Invalid Equipment

Certified Fitters

C. R. NEWTON CO. LTD.

1575 S. BERETANIA STREET
HONOLULU, HAWAII 96814
TELEPHONE 949-8389 OR 949-6757

OXYGEN AIR-CONDITIONED

24-HOUR SERVICE

Physician's

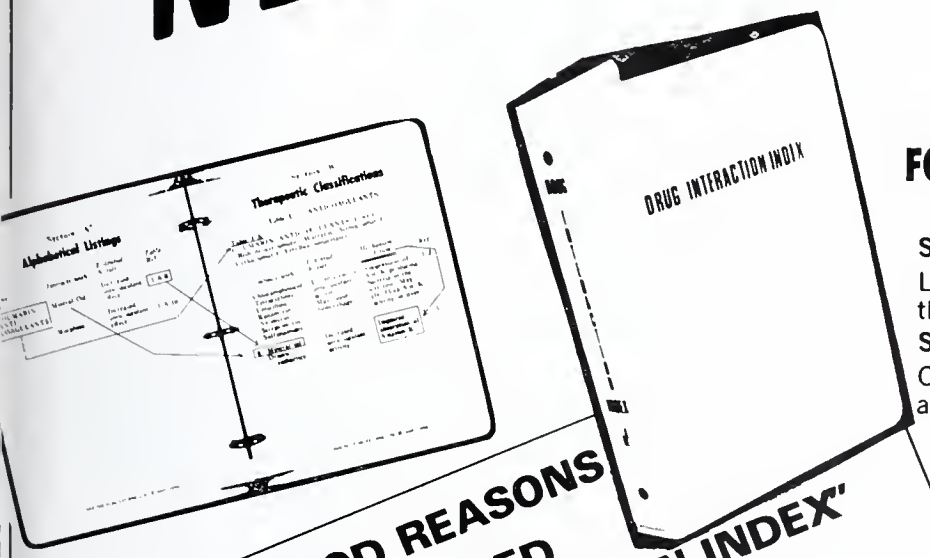


531-0477

AMBULANCE SERVICE, INC.

Hawaii's Finest

NEW! DRUG INTERACTION INDEX



FOR PHARMACISTS & PHYSICIANS

SECTION "A"
Lists drugs alphabetically, making it easy to find the drugs in question.

SECTION "B"
Contains Therapeutic Classifications and serves as source of more detailed information when needed.

16 GOOD REASONS WHY YOU NEED "DRUG INTERACTION INDEX"

1. Over 300 listings of drugs by Generic name thus making Index applicable in Canada, USA and other countries.
2. All drugs are listed individually as are those drugs used in everyday practice.
3. Alphabetical listing gives quick finger tip reference.
4. Immediate and concise information as to possibility of an interaction and potential result.
5. Every drug cross-indexed at least three times.
6. Twenty-one (21) Therapeutic Tables with 62 Sub-classifications.
7. Therapeutic Classifications give further detail as to potential result.
8. Also describes mechanism of action, if known.
9. All listings and therapeutic classifications from documented sources (bibliographies included).
10. Explains and gives examples for most drug interactions.
11. Can be used to prevent possible drug interactions.
12. Can be used to aid in the diagnosis of possible drug-induced illness.
13. Designed so that Index can be easily and readily used while dispensing.
14. Readily adaptable to dispensing counter, library shelf, or doctor's bag.
15. Index to be updated with supplements.
16. Ring binder form permits ease of insertion and maintenance.

MECHANISMS OF ACTION

Recognizing the fact that Drug Interaction is a relatively new field and that many professional persons wishing to use the Index might find it difficult to draw a mental picture of some mechanisms of action, we have given an explanation for some Drug Interactions and examples of each one.

FAST AND INFORMATIVE

We believe that the DRUG INTERACTION INDEX provides for the first time an ideally fast and informative guide for the busy pharmacist. To be sure, there will be times when further research and detail will be necessary, but for that quick, single, hour-to-hour, day-to-day reference, the DRUG INTERACTION INDEX will serve a very useful need.

DISTINCTIVE FORMAT

Facilitates efficacy of Index — quickly indicates whether or not a drug already in use or about to be used is likely to react with other drugs or components of the diet.

ASSISTANCE TO PHARMACIST

While primarily intended as a guide, proper utilization of this Index will assist the pharmacist in advising not only how to take medication, but what or what not to take with it, and will thus lead to better patient care in the area of medication and will be an effective first line of defence against therapeutic misadventure.

Meditec Publications Ltd.
1635 Abbott St., Park Medical Building, Kelowna, B. C., Canada

Please send _____ copies of the Drug Interaction Index @ $20.00 per copy. Enclosed is my remittance in full totalling $_____.

Name_____

Address_____

City_____ State_____ Zip Code_____

(Applicable for use in USA — Canada and other Countries)



Indications: NegGram is indicated for the treatment of urinary tract infections caused by sensitive pathogenic organisms. Disc sensitivity testing with the 30 mcg. disc is recommended. NegGram is particularly useful against gram-negative bacteria (e.g., Proteus, *E. coli*, Aerobacter, Klebsiella, and a few strains of Pseudomonas).

Warning: *Usage in Pregnancy.* Safe use of NegGram during the first trimester of pregnancy has not been established. However, the drug has been used during the last two trimesters without producing apparent ill effects in mother or child.

Precautions: Blood counts and renal and liver function tests should be performed periodically if treatment is continued for more than two weeks. NegGram should be used with caution in patients with liver disease, severely impaired kidney function, epilepsy, or severe cerebral arteriosclerosis.

Patients should be cautioned to avoid undue exposure to direct sunlight while receiving NegGram. Therapy should be discontinued if photosensitivity occurs.

Bacteria resistant to NegGram may emerge rapidly. Therefore, cultures and bacterial sensitivity tests should be repeated if the clinical response is unsatisfactory or if a relapse occurs.

When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking NegGram, a false-positive reaction for glucose may be obtained, due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (e.g., with Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to the liberated glucuronic acid.

Incorrect values may be obtained for urinary 17-keto and ketogenic steroids in patients receiving NegGram, because of an interaction between the drug and the *m*-dinitrobenzene used in the usual assay method. In such cases, the Porter-Silber test for 17-hydroxycorticoids may be used.

Adverse Reactions: Gastrointestinal disturbances include abdominal pain, nausea, vomiting, and diarrhea. Allergic reactions include rash, pruritus, urticaria, angioedema, eosinophilia, and joint stiffness and lethargy. Other reactions have been drowsiness, weakness, headache, dizziness and vertigo, and rarely, anaphylactoid reaction, cholest
paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia w
in some patients may have been associated with a deficiency in act
of glucose-6-phosphate dehydrogenase. Photosensitivity reactions,
marily involving exposed skin surfaces, have disappeared after ther
was discontinued.

Reversible subjective visual disturbances without objective findings h
occurred infrequently (generally with each dose during the first few c
of treatment). These reactions include overbrightness of lights, cha
in color perception, difficulty in focusing, decrease in visual acuity,
double vision. They usually disappeared promptly when dosage was
duced or therapy was discontinued.

Toxic psychosis or brief convulsions have been reported rarely, usu
following excessive doses. In general, the convulsions have occurre
patients with predisposing factors such as epilepsy or cerebral a
riosclerosis. In infants and children receiving therapeutic doses
NegGram, increased intracranial pressure with bulging anterior fonta
papilledema, and headache has occasionally been observed. Altho
the mechanism of this phenomenon is unknown, the signs and sympt
disappeared rapidly with no sequelae when treatment was discontinu

Dosage and Administration: *Adults.* The recommended dosage for in
therapy in adults is 1 Gm. administered four times daily for one or
weeks (total daily dose, 4 Gm.). For prolonged therapy, the total d
dose may be reduced to 2 Gm. after the initial treatment period.

Children. Until further experience is gained, NegGram should not
administered to infants younger than one month. Dosage in child
12 years of age and under should be calculated on the basis of b
weight. The recommended total daily dosage for initial therapy is
mg./lb./day (55 mg./kg./day), administered in four equally divi
doses. For prolonged therapy, the total daily dose may be reduced
15 mg./lb./day (33 mg./kg./day).

How Supplied: Caplets® of 250 mg., scored, bottles of 56 and 10
Caplets of 500 mg., scored, bottles of 56, 500, and 1000.

Winthrop Winthrop Laboratories, New York, N.Y. 10016

Our "Angels"

Page

Amfac Distribution Company
Drug Department 157

Arch Laboratories
Dicarbosil 211

Ayerst Laboratories
Premarin 154, 155

Barnes-Hind Laboratories
Tinver Lotion 153

Bishop Trust Co., Ltd. 146

Brainard & Black, Ltd. 218

Bureau of Medical Economics, Ltd. 216

Burroughs Wellcome & Co. (USA), Inc.
Neosporin 148

Campbell Soup Company
Asparagus 183

Carnation Company 204

Coca-Cola Bottling Company of Honolulu, Inc. 221

Control Data Corporation 216

Hanalei Colony Resort 215

Hawaii Medical Service Association 206

Hawaii State Hospital 213

Honolulu Medical Group, The 214

Lederle Laboratories
Achrostatin V 160

Lily, Eli, & Co.
Cordran Tape 162

Mead Johnson Laboratories
Prosobee 149

Page

Medical Industries, Ltd. 219

Medical Placement Bureau 220

Meditec Publications, Ltd. 223

National Drug Company
Orenzyme/AVC Insert (between 152 & 153)
Tepanil/Quinamm Insert (between 148 & 149)

Newton, C. R., Co., Ltd. 222

O'Leary, Lydia, of Hawaii 219

Optical Dispensers of Hawaii, Inc. 221

Pacific Land Company 218

Physician's Ambulance Service, Inc. 222

Robins, A. H., Co., Inc.
Phenaphen/Dimetapp Insert (between 216 & 217), 217

Roche Laboratories
Efudex 142, 143
Librax 158, 159
Valium 228
Noludar 161 and 210

Searle, G. D., & Co.
Demulen/Ovulen 226, 227

Smith Kline & French Laboratories
Thorazine 156

Star-Bulletin Printing Company 220

Stuart Pharmaceuticals, Division of Atlas Chemical Industries, Inc.
Mylanta 144

Trent Medical Personnel Bureau 203

Williams Mortuary 225

Winthrop Laboratories
NegGram 224
Talwin Oral 150, 151, 152

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association



An excerpt from No. 1 of a new series from Searle*

"The Ecology of Birth Control"

75 million more Americans—what impact on health care?

Because of a declining birthrate in the United States—attributable in no small measure to the widespread use of contraceptives—our population in thirty years is expected to be *only* 280 million, while the world population is expected to double, reaching 7 billion.

But the word "only" has an ironic ring to ecologists who warn of cities resembling overcrowded, contaminated rat colonies, of respiratory and mental diseases reaching epidemic proportions and of a health-care community virtually overwhelmed by the burden.

The global consequences may be no less devastating. Ecologists estimate that every American has roughly fifty times the negative impact on the Earth's life-support systems of, say, a citizen of India. In these terms, adding 75 million Americans would be equivalent to adding 3.7 billion Indians to the world population.

**For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.* Explored in the forthcoming issues will be the role of birth control on family pressures and its effects on the family; the influences of poverty, ethnic factors and marital status; its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

JULY / AUGUST 1971

HAWAII MEDICAL JOURNAL

VOLUME 30 / NUMBER 4

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
OCT 13 1971



Annual House of Delegates Proceedings

Call it what you will, it may be premalignant

Before

3/29/67 Before therapy with 5%-FU cream. Patient P. T shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

ınd Efudex® (fluorouracil) 5% cream can resolve it.

ıll it actinic, solar or senile keratoses, any regard it as "precancerous."[1,2]

pical fluorouracil, considered by some dermatologists to be a major vance in the treatment of multiple solar keratoses,[3,4] offers the physi- n a relatively inexpensive alternative to cryosurgery, electrodesic- ion and cold knife surgery. Of the topical fluorouracils available, only udex offers 2% and 5% solution and 5% cream formulations—formula- ns that have proved effective in the treatment of these mutliple lesions.

sual duration of therapy, 2 to 4 weeks.

ıdies showed that with the 2% and 5% Efudex preparations, the usual ration of therapy was only 2 to 4 weeks.[5] Other studies with topical orouracil revealed that when concentrations of less than 2% were d, significant numbers of lesions recurred.[6]

reats the lesions you can't see, too.

ımerous lesions, not apparent prior to 2% and 5% Efudex therapy, nifested themselves by definite reactions, while intervening skin mained relatively unaffected.[5] The early eradication of these subclini- lesions (which may otherwise have undergone further progression) obably accounts for the reduced incidence of future solar keratoses in tients treated with topical fluorouracil—especially with 5% ncentrations.[6]

ow to identify solar keratoses.

pically, the lesion—a flat or slightly elevated brown to red-brown pule—is dry, rough, adherent and sharply defined. Multiple lesions e the rule.

redictable therapeutic response.

ıe response to a typical course of Efudex therapy is usually aracteristic and predictable. After 3 or 4 days of treatment, erythema gins to appear in the area of keratoses. This is followed by a moderate intense inflammatory response, scaling and occasionally moderate nderness or pain. The height of this response generally occurs two eeks after the start of therapy and then begins to subside as treatment stopped. Within two weeks of discontinuing medication, the flammation is usually gone. Lesions that do not respond should biopsied.

ferences: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, une & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T., and Honeycutt, W. M.: reatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): armaceutical Therapeutics in Dermatology, Springfield, Ill., Charles C Thomas, 1968, 92. 3. Belisario, J. C.: *Cutis*, *6*:293, 1970. 4. Sams, W. M.: *Arch. Derm.*, *97*:14, 1968. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and ein, E.: *Cancer*, *25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

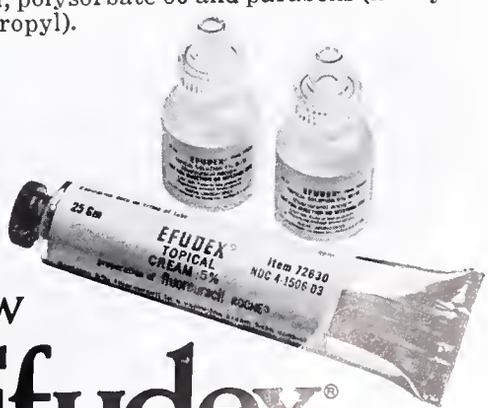
Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



now

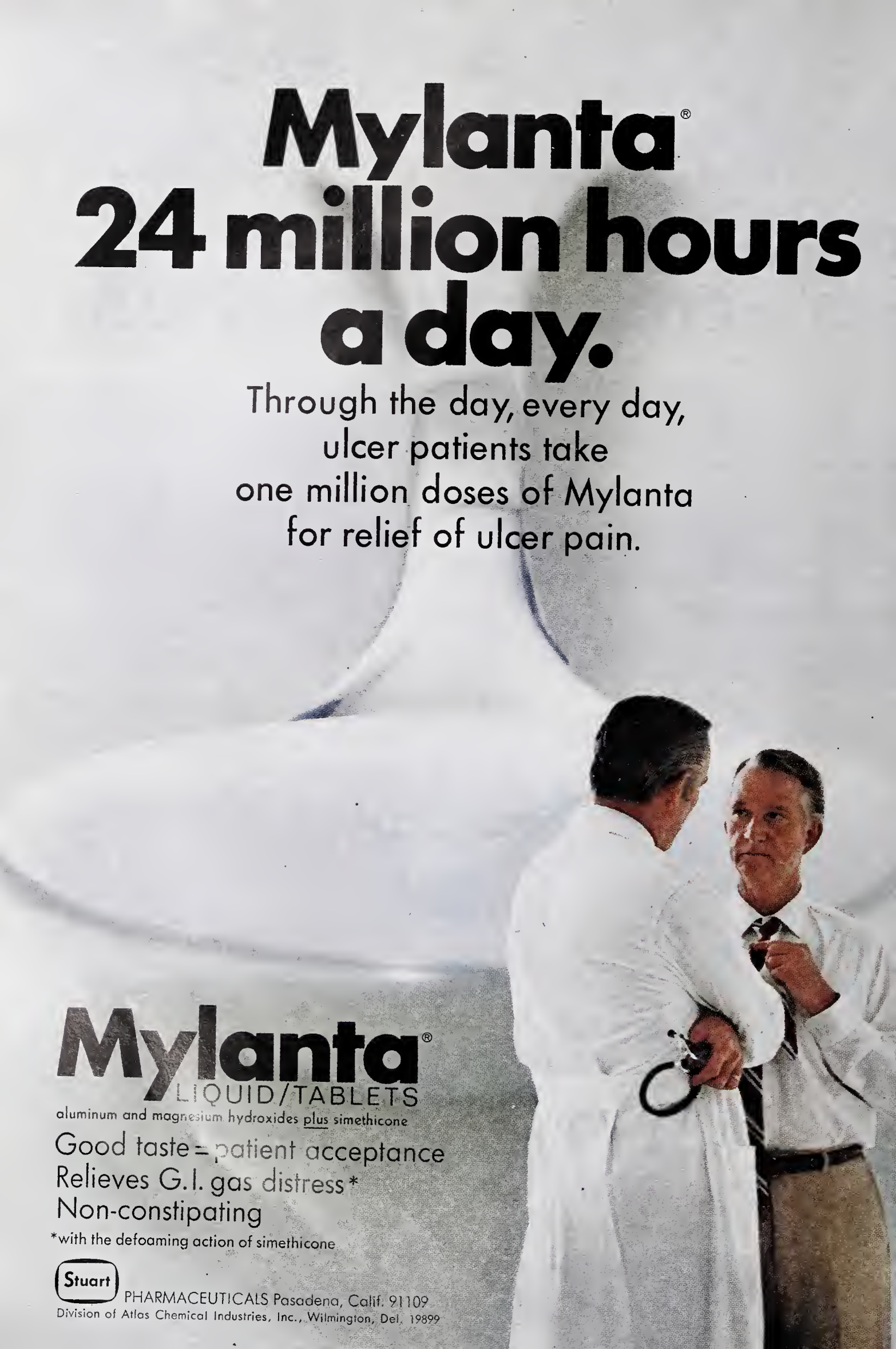
Efudex®

(fluorouracil)

cream/solution

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS

aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

HAWAII MEDICAL JOURNAL

VOLUME 30, NUMBER 4

JULY-AUGUST, 1971

$6.00 A YEAR • $1.00 A COPY

Advertising Representative
LILITH JURRY
Phone 946-0053

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1971, by the Hawaii Medical Association, Honolulu, Hawaii.

Entered as second class matter. October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

Published Bi-Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, MARILYN O. WALL
Associate Editor, MERYL H. HABER, M.D.
Contributing Editor, ROBERT H. MOSER, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.

The Hawaii Medical Association

Officers 1971

President • HERBERT Y. H. CHINN, *Honolulu*
President-Elect • WILLIAM E. IACONETTI, *Maui*
Past President • JOHN J. LOWREY, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • THOMAS P. FRISSELL, *Honolulu*

County Presidents

Hawaii County • VERNE ADAMS, *Pahala*
Honolulu County • THOMAS P. FRISSELL, *Honolulu*
Kauai County • CHARLES CUSTER, *Waimea*
Maui County • J. MARK B. SOWERS, *Wailuku*
Delegate to AMA • GEORGE H. MILLS, *Honolulu*
Alt. Delegate to AMA • THEODORE T. TOMITA, *Honolulu*

Councillors 1971

Maui • SAKAE UEHARA
Honolulu • GROVER H. BATTEN
Honolulu • WILLIAM W. L. DANG
Honolulu • H. WILLIAM GOEBERT, JR.
Hawaii • ED B. HELMS
Kauai • PETER KIM

Officers—County Societies—1971

HAWAII		**HONOLULU**
VERNE ADAMS •	President	• THOMAS FRISSELL
DEWITT H. SMITH •	Vice President	• WINFRED LEE
EDWARD BALLERINI •	Secretary	• WILLIAM DANG
ALLAN TAKASE •	Treasurer	• WILLIAM F. MOORE, JR.
MAUI		**KAUAI**
J. MARK B. SOWERS •	President	• CHARLES CUSTER
DENIS FU •	Vice President	• KATOK CHUANG
JOHN WITHERS •	{Secretary} {Treasurer}	• ROBERT BERRY

For Her Future... A Living Trust Now...

She's growing up fast. Before you know it, it'll be time for college.
A good education is important — and you want to make sure she gets the best.
Securities and other assets set aside now in a living trust can be managed in a knowledgeable, impartial manner that will insure the income to see her through college, and later provide that "extra" financial help young families need. Start a trust for *her* future now — see us today . . .

BISHOP TRUST CO., LTD.

Bishop and King • Phone 536-3771
Honolulu, Hawaii 96813



HAWAII MEDICAL JOURNAL

Contents

Vol. 30, No. 4 • July-August, 1971

Articles

MEDICAL LECTURE—Changing Concepts of Death 251
John J. Lowrey, M.D.

Radical Mastectomy for Carcinoma of the Breast 258
C. M. Burgess, M.D., and J. F. Balfour, M.D.

A Toxicologic View of Marijuana 262
Louis J. Casarett, Ph.D., and Randall C. Baselt, B.S.

The Conquest of Scurvy and the Discovery of Hawaii: An Ethnobotanical Triumph 266
James J. Ball, M.D.

Group A Beta Hemolytic Streptococcal Bacteremia Review and Report of 14 Cases 270
Stephen M. Kreitzer, B.A.

The Pacific Southwest Regional Medical Library Service 274
Nelson J. Gilman

Editorials

Effecting "Death with Dignity" 278

Sickness Care vs. Health Care 279

Features

Book Reviews 285

County Society Reports 334

Hawaii Academy of General Practice 280

Hawaii Medical Association

Council Meeting 288

House of Delegates Proceedings 293

In Memoriam—Doctors of Hawaii 283

Inside HMA 281

New Members 291

Notes and News 286

Our New President 292

President's Page 276

Slants and Angles 282

X-ray View Box 284

Hawaii Pharmacists' Bulletin

President's Corner 336

President's Message 338

Board of Directors Meeting 338

Cover: Seal of the Hawaii Medical Association

The ultimate



test:

Confirms the value of Talwin® in private practice

analgesic efficacy comparable to meperidine and morphine with a *minimum* of significant adverse effects

In postoperative patients: less circulatory depression with Talwin

In a double-blind study of 342 postop patients, circulatory depression occurred in 13.2% of 174 patients receiving morphine; in 5.4% of 168 patients receiving Talwin.[1]

. . . and in other patients: less respiratory and circulatory depression with Talwin

In a double-blind study of 3 narcotic analgesics and Talwin in 118* patients with suspected acute myocardial infarction, Talwin caused a significantly lower incidence in the fall of systolic blood pressure than the 3 narcotics when the initial pressure was 120 mm. Hg or higher. Unlike the narcotics, Talwin caused a statistically significant *rise* in the systolic blood pressure of patients with initial pressures of less than 120.[2]

In a study of a series of patients given Talwin or meperidine while anesthetized for surgery, the investigators concluded: "It would therefore appear that pentazocine is a much safer drug in respect of respiratory depression than pethidine [meperidine], particularly when repeated injections are to be given, e.g., postoperatively or in obstetric practice."[3]

. . . and less of other adverse effects associated with narcotic analgesics

Compared to morphine, Talwin is relatively free from urinary retention and constipation.

Is less likely to cause nausea, vomiting and diaphoresis than meperidine.

See next page for a complete discussion of adverse reactions and a brief summary of other Prescribing Information.

available in 3 dosage strengths—all within the range of recommended dosage
Talwin is available in 30 mg., 45 mg., and 60 mg. strengths to provide analgesia specific to patients' needs throughout the course of therapy. Most studies indicate that the higher dosage strengths produce little, if any, increase in the incidence of adverse reactions.

References: 1. Wallace, George: *Int. Surg. 53*:135, Feb. 1970.
2. Scott, M. E. and Orr, Rosemary: *Lancet 1*:1065, May 31, 1969.
3. Davie, I. *et al.*: *Brit. J. Anaesth. 42*:113, Feb. 1970.

*Other drugs studied: diamorphine and methadone.

Injectable
Talwin®
Brand of
pentazocine
(as lactate)

bulwark against moderate to severe pain

Injectable Talwin®

Brand of **pentazocine** (as lactate)

- **tolerance to analgesic efficacy has not been observed**
- **not subject to narcotic controls**

Contraindications: Talwin should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. Special care should be exercised in prescribing pentazocine for emotionally unstable patients and for those with a history of drug misuse. Such patients should be closely supervised when long-term therapy is contemplated. There have been instances of psychological and physical dependence on Talwin in patients with such a history and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in symptoms such as abdominal cramps, elevated temperature, rhinorrhea, restlessness, anxiety, and lacrimation. Even when these occurred, discontinuance has been accomplished with minimal difficulty. In the rare patient in whom more than minor difficulty has been encountered, reinstitution of parenteral Talwin with gradual withdrawal has ameliorated the patient's symptoms. Substituting methadone or other narcotics for Talwin in the treatment of the Talwin abstinence syndrome should be avoided.

In prescribing parenteral Talwin for chronic use, particularly if the drug is to be self-administered, the physician should take precautions to avoid increases in dose and frequency of injection by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Just as with all medication, the oral form of Talwin is preferable for chronic administration.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under twelve years of age is limited, the use of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* The possibility that Talwin may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: The most commonly occurring reactions are: nausea, dizziness or lightheadedness, vomiting, euphoria.

Infrequently occurring reactions are—*respiratory:* respiratory depression, dyspnea, transient apnea in a small number of newborn infants whose mothers received Talwin during labor; *cardiovascular:* circulatory depression, shock, hypertension; *CNS effects:* sedation, alteration of mood (nervousness, apprehension, depression, floating feeling), dreams; *gastrointestinal:* constipation, dry mouth; *dermatologic including local:* diaphoresis, sting on injection, flushed skin including plethora, dermatitis including pruritus; *other:* urinary retention, headache, paresthesia, alterations in rate or strength of uterine contractions during labor. Rarely reported reactions include—*neuromuscular and psychiatric:* muscle tremor, insomnia, disorientation, hallucinations; *gastrointestinal:* taste alteration, diarrhea and cramps; *ophthalmic:* blurred vision, nystagmus, diplopia, miosis; *other:* tachycardia, nodules and ulceration at injection site, weakness or faintness, chills, moderate transient eosinophilia, allergic reactions including edema of the face.

See *Acute CNS Manifestations* and *Drug Dependence* under **WARNINGS.**

Dosage and Administration: *Adults, Excluding Patients in Labor.* The recommended single parenteral dose is 30 mg. by intramuscular, subcutaneous, or intravenous route. This may be repeated every 3 to 4 hours. Doses in excess of 30 mg. intravenously or 60 mg. intramuscularly or subcutaneously are not recommended. Total daily dosage should not exceed 360 mg. As with most parenteral drugs, when frequent daily injections are needed over a prolonged period, intramuscular administration is preferable to subcutaneous. In addition, constant rotation of injection sites (e.g., the upper outer quadrants of the buttocks, mid-lateral aspect of the thighs, and the deltoid areas) is recommended.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin in this age group is not recommended.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, Intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: *Ampuls of 1 ml. (30 mg.), 1½ ml. (45 mg.), and 2 ml. (60 mg.),* each 1 ml. containing Talwin (brand of pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in water for injection. Boxes of 10, 25, and 100.

Multiple dose vials of 10 ml., each 1 ml. containing Talwin (brand of pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in water for injection. Boxes of 1.

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

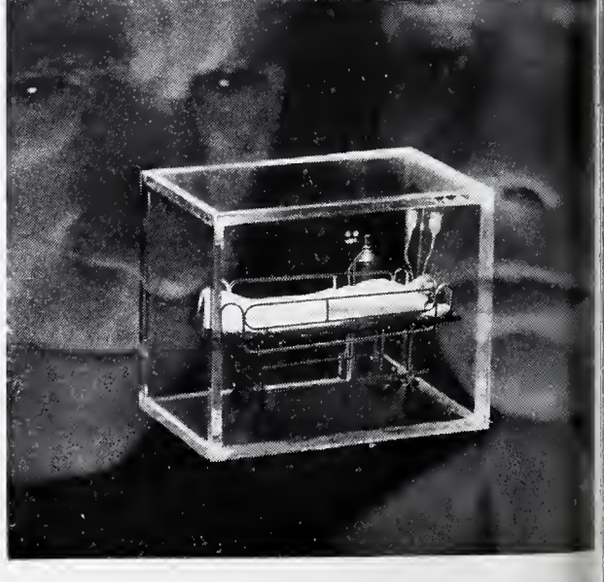
Winthrop

WINTHROP LABORATORIES, NEW YORK, N. Y. 10016 (1512)

the recovery room: ultimate test for Talwin®

Brand of **pentazocine** (as lactate)

in private practice



Protein powerhouse!



PROSOBEE®
milk-free formula with soy isolate
...a protein powerhouse

For the "problem feeder" whose serum protein reserves ore low—PROSOBEE provides an extro boost of protein to help bring reserves up ond help keep them there ※ 25% or more protein thon other soy isolote formulos ※ milk-like color, smoothness and flavor for greoter occeptance ※ convenient 32-fl. oz. PROSOBEE Ready-To-Use—no chance for mixing error. **For Hospital Use:** NURSETTE® disposoble bottles, 4- ond 8-fl. oz.; for the BENIFLEX® Disposoble Nurser System, 32-fl. oz. cons.

Composition: 87% water, 3.9% sugar, 3.1% soy oil, 2.7% corn syrup solids, 2.7% soy protein isolate, 0.26% dicalcium phosphate, 0.26% potassium citrate, 0.10% lecithin, 0.05% calcium carbonate, 0.04% dibasic magnesium phosphate, 0.03% salt, 0.03% carrageenan, 0.03% guar gum, 0.02% DL-methionine, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, riboflavin, niacinamide, sodium iron pyrophosphate, potassium iodide, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, choline chloride, inositol, cupric sulfate, manganese sulfate and zinc sulfate.

©1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 77270R

Mead Johnson
LABORATORIES

"I'M FEELING
MUCH BETTER, DOCTOR."

"SO AM I."



HMSA is the "get-well card" that leaves you *both* feeling better. Offers patient and physician lasting relief from medical economic problems. Once again, March, July and November are individual enrollment months. An excellent time to remind unprotected patients about the benefits of belonging to this non-profit community organization. It's good for what ails them. And you.

HMSA

Hawaii-owned for Hawaii's own
HAWAII MEDICAL SERVICE ASSOCIATION
BLUE SHIELD PLAN FOR HAWAII
Member Western Conference of Prepaid Medical Service Plans

HONOLULU: 1504 Kapiolani Blvd., P. O. Box 860, Phone 944 2110
WAILUKU, MAUI: P. O. Box 956, Phone 323-912
LIHUE, KAUAI: P. O. Box 27, Phone 245-3393
HILO, HAWAII: P. O. Box 1356, Phone 935-5441
KAILUA-KONA, HAWAII: P. O. Box 1219, Phone 329-3030

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Controindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Worning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-107/4/71/U S PATENT NO 3,001,910



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

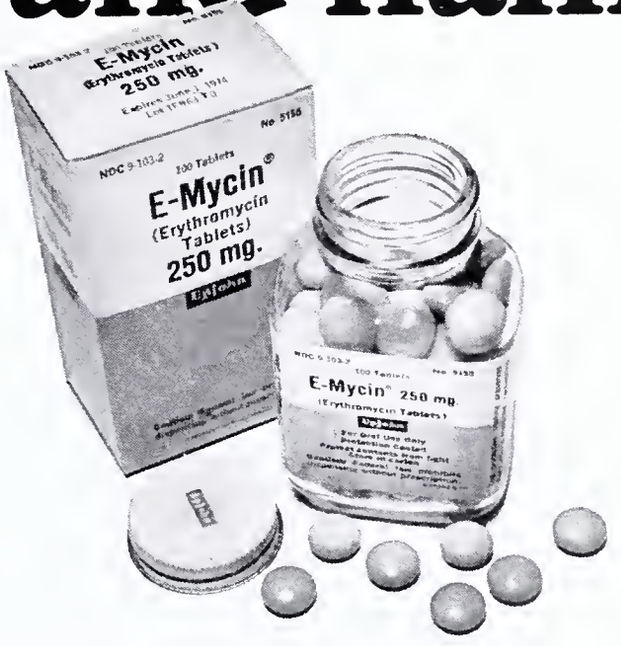
Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

The least expensive* erythromycin has a brand name



Upjohn has reduced the price of E-Mycin® (erythromycin, Upjohn) by 25% following a change in manufacturing facilities. That makes E-Mycin the lowest priced* erythromycin on the market. Now your patients can have an Upjohn drug and save money besides.

*Prior to June 1, 1971

E-Mycin®

250 mg. tablets

(erythromycin, Upjohn)

A70-9803

Upjohn The Upjohn Company Kalamazoo, Michigan 49001

© 1970 by The Upjohn Company


ESTROGEN
DEFICIENT
WOMAN:

You see her from 45 to 55 with

hot flushes
night sweats
fatigue
headache
palpitations
emotional distress

TREAT HER WITH PREMARIN (Conjugated Estrogens, U.S.P.). PREMARIN offers specific, effective replacement therapy for relief of menopausal symptoms—both physical and emotional—due to estrogen deficiency. It usually provides a "sense of well-being"... helps many patients maintain a more positive outlook.

KEEP HER ON PREMARIN (Conjugated Estrogens, U.S.P.). Continued use of PREMARIN after menopausal symptoms have abated can help protect against further degenerative changes related to estrogen deficiency—changes that often begin in the reproductive organs and extend rapidly to body tissues and skeleton.

REPLACEMENT THERAPY AT ANY STAGE. The estrogen deficient woman can benefit from long term replacement therapy with PREMARIN *at any stage*—whether she is 45 and suffering symptoms of the menopause... a grandmother of 60 with atrophic vaginal tissue... or an even more elderly patient with osteoporosis. PREMARIN therapy is remarkably well tolerated, and relatively inexpensive.

BRIEF SUMMARY

PREMARIN® (Conjugated Estrogens, U.S.P.).

Indication: PREMARIN is specific for replacement therapy of the estrogen deficiency state characteristic of the menopause and the postmenopause.

Caution: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

Suggested Usual Dosage: Menopausal and postmenopausal estrogen deficiency—PREMARIN: 1.25 mg. to 3.75 mg. daily, depending on severity of symptoms. Dosage should be tailored to individual needs of patient. Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

Note: If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. Continue this individualized dosage in subsequent cyclic regimen. *Failure to control bleeding or unexpected recurrence is an indication for curettage.*

Atrophic vaginitis, pruritus vulvae: Cyclically, 1.25 mg. to 3.75 mg. or more is given, depending on tissue response of individual patient.

Available in 4 potencies: *Tablets*—No. 865—2.5 mg. (purple); No. 866—1.25 mg. (yellow); No. 867—0.625 mg. (red); and No. 868—0.3 mg. (green). In bottles of 100 and 1,000.

AYERST LABORATORIES
New York, N.Y. 10017

Ayerst®

7053

therapy for all stages of estrogen deficiency

NATURAL ESTROGEN THERAPY

PREMARIN®

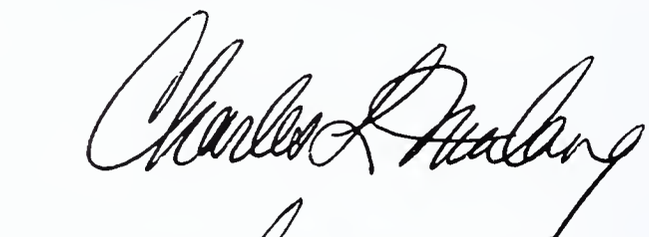
BRAND OF

CONJUGATED ESTROGENS, U.S.P.

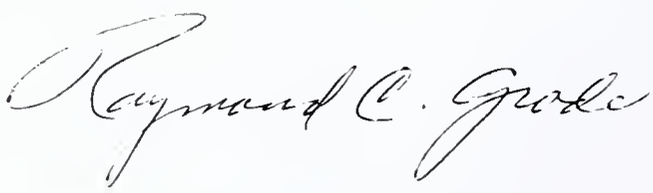
medicine is not a cut-rate field.

Too much is at stake to cut corners by cutting service. At Amfac you will find the lowest prices and the best terms consistent with the service you deserve and the standards you demand. Large, local stock. Fast, dependable four-times-a-day delivery service. 30 days to pay.

At Amfac medicine is not a cut-rate field.


MANAGER


SALES MANAGER — DRUG


MANAGER — MEDICAL EQUIPMENT

Amfac
DISTRIBUTION COMPANY
Drug Department
PHONE 533-0315

A
BUILDING BLOCK
TO RECOVERY



Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple



Trichomonads... monilia... bacteria
You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC
Cream (aminacrine hydrachloride 0.2%, sulfanilamide 15.0%, allantain 2.0%)

Suppositories (aminacrine hydrachloride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.14 Gm.)

Contraindications: Known sensitivity to sulfonomides.
Precautions/Adverse Reactions: The usuol precoutions for topicol ond systemic sulfonomides should be observed becouse of the possibility of obsorption. Burning, increosed locol discomfort, skin rosh, urticorio or other monifestotions of sulfonomide toxicity ore reosons to discontinue treotment.
Dosage: One opplicotorful or one suppository introvoginolly once or twice doily.
Supplied: Creom – Four-ounce tube with or without opplicotor. Suppositories – Box of 12 with opplicotor.

TRADEMARK: AVC AV-104 2/71 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular

Empirin® Compound with Codeine, gr. ½ or gr. 1

Helps overpower pain

Each tablet contains: aspirin gr. 3½,
phenacetin gr. 2½, caffeine gr. ½.
No. 3 contains codeine phosphate* (32.4 mg.) gr. ½.
No. 4 contains codeine phosphate* (64.8 mg.) gr. 1.
*(Warning—may be habit forming.)

CIII Empirin Compound with Codeine is now classified in Schedule III. Available on oral prescription and may be refilled 5 times within 6 months, unless restricted by State law.

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

An intestinal autobiography of rage, contentment and horror*

"Feeling unfairly taxed by the government (Internal Revenue Service) and not given enough attention by A.U.O. [an experimenter to whom the subject became very attached], he became overtly critical and accusatory. He shouted, raged, and threatened to quit."*



"The motility that day was quiet. This type of recording is seen regularly when he is relaxed and contented and the laboratory seems peaceful."*



He was overwhelmed by "paralyzing horror" when told he would need a partial laryngectomy for removal of an early carcinoma; "...the activity of the ileum virtually ceased for over a five-minute period...."*



Background

*Data presented here derive from a 13-year ongoing study by Henry Harrison Sadler, M.D., and Aline Underhill Orten, Ph.D., at Wayne State University. Their findings, which demonstrate a correlation between the emotional state of a human subject and the motility of an isolated segment of his ileum, were published in the April, 1968, *American Journal of Psychiatry*, volume 124, page 1375.

The subject is a 56-year-old man with a 40-cm Thiry loop of ileum created as a result of emergency surgery. A person of modest attainment and simple tastes, the subject depends on the investigators as he might his own family. His full-time job is as a "human laboratory," and throughout the 13-year perio of the study, he has taken great personal prid in his own participation.

A story charged with emotion

The graphs on the facing page are intestinal motility readings on a human subject experiencing the emotions of rage, contentment and horror (see "Background" below left). This "intestinal autobiography" dramatizes the point that certain emotions correlate with specific patterns of G.I. motility.

The visceral clutch and functional G.I. disorders

The gut response to stress has been amply demonstrated in many functional G.I. disorders. Nervous diarrhea and irritable colon syndrome, for example, are disorders associated with abnormal G.I. motility. And these disorders are commonest among patients sensitive to life-stress situations productive of conflict and excessive anxiety.

Librax® calms anxiety, calms the gut

In these areas of G.I. pathology, Librax has become a mainstay of adjunctive therapy. Reason? Effective two-way calming action. Librax, by relieving excessive anxiety, not only helps calm emotional overreaction to stress, it controls intestinal hypermotility, too. Depend on Librax—the only drug that combines the well-known antianxiety action of Librium® (chlordiazepoxide HCl) and the potent, dependable antisecretory/antispasmodic action of Quarzan® (clidinium Br).

1 or 2 capsules, 3 or 4 times daily in the treatment of nervous diarrhea and irritable colon syndrome

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

In functional G.I. disorders, adjunctive Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

calms anxiety, calms the G.I. tract

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



for complete recovery

MERCEDES-BENZ

in the showroom of

Eurocars of Hawaii, Ltd.

704 Ala Moana at Coral

Phone: 531-5971

Physician, computerize thyself.

Do your billing by computer. You'll know where you stand, cash-wise, at all times.

You'll have a daily record of all charges and payments. Recapped weekly, monthly and anually to reveal which services are most productive and to indicate trends in your business.

You'll get out from under insurance paper work.

And be able to spot slow-paying patients immediately.

Conversion is easy... just a few hours, spent almost entirely in our offices.

Charges are based on how many patients you have per month.

And when hidden billing expenses are considered... typing, photocopying, filing, etc... our computers, staff and proven Accounts Receivable System* are yours for comparable cost at a great saving of your professional time.

Call us at 536-3771. And computerize thyself.

Bishop Computer Center
A division of Bishop Trust Co., Ltd / Bishop & King Streets

* Acquired from Data-Pac, Inc.

Now available for your prescribing needs



Cordran® Tape

Flurandrenolide Tape (4 mcg. per sq. cm.)

Additional information available upon request • Eli Lilly and Company, Indianapolis, Indiana 46206

000121

Lilly

Medical Lecture

Changing Concepts of Death

JOHN J. LOWREY, M.D.

DEATH IS inevitable, but the time of death can be put off nowadays to a degree never dreamed of a few years ago. As a medical student, in the late thirties, I watched elderly people die of lobar pneumonia. There was no treatment. It was a rapid, acute illness, which mercifully carried away a great many elderly, bedridden patients. Sir William Osler, twenty years before, called it "the old man's friend." In medical school we were beginning to hear of some new miracle drug from Germany, a "sulfa" drug, but it was penicillin, discovered by Alexander Fleming in 1928 and purified later in 1940 by others that really ushered in the antibiotic era and gave physicians the ability to cure many previously fatal infectious diseases. The question arises: *should* every patient with infection today be treated for his infection, regardless of what else may be wrong with him?

Life expectancy for men in Hawaii in 1930 was 53 years, and thirty years later in 1960 had risen to 69 years.[1] As life is prolonged, degenerative conditions of blood vessels, heart, and brain increasingly take their toll. Rare are the homes or family units today which can accept from hospital for home care an ailing, senile, or incompetent relative or friend. And so one will end up in some kind of nursing home. Standards of nursing homes over the past few years have been upgraded to meet Federal requirements for payment under Federal programs. Someone has suggested that the degree of civilization of a community can be judged by the manner of care and compassion shown for helpless individuals. This argument may be so, and raising the standards of care is done with the best intentions; however, I submit that to prolong the life of a tube-fed, permanently unconscious, bedridden patient is not humane.

Let me make it crystal clear: I am not advocating euthanasia, which by definition according to Webster is "an act of inducing death painlessly." However, allowing a person to slip away in dignity when his time has come is to me preferable to extraordinary measures which cannot possibly succeed in restoring a person to a life he would want to live. This life or degree of life worth saving will forever be difficult to define, and where differences of philosophy, religion, training, and beliefs exist, this can lead to pitiful and disastrous confrontations.

To get people thinking about these matters and for you to consider during the rest of this presentation, I would like to suggest that while we are still competent, we should write a statement saying under what conditions we wish efforts to keep

Read before the Social Science Association of Hawaii, April 5, 1971. Dr. Lowrey is the immediate past president of the Hawaii Medical Association. His address is reprinted here from the *Honolulu Star-Bulletin* at the direction of the HMA House of Delegates.

us alive should cease. This idea will surely be repugnant to some; but an idea, to be accepted, must first be expressed and discussed. Such a statement, notarized and witnessed if necessary, would help families, their pastors, and their physicians to meet these tragic problems which occur daily. There is no reason why it should not be as routine as making one's will. Such a statement would help people to face the realities of life, which include dying. The time has come with the progress of education, the advances of medicine, overpopulation, and fantastic medical costs when we must evaluate the quality of life and existence.

The Honolulu *Star-Bulletin's* excellent series of articles in May, 1970, entitled "As Death Draws Near," introduced many of the problems. My presentation will discuss some other aspects of death and suggest the individual early in life, before he becomes a patient, should think and plan for his future, including under what circumstances he wishes to be allowed to die. To what extent he can, legally, is not settled but at least he can put down his feelings on paper. The *Star-Bulletin* articles gave considerable space to religious aspects, which are of paramount importance in molding the individual's beliefs and conduct. My presentation will deal more with some of the medical advances which have brought about changing concepts of death and the individual's right of choice as to when and how he wishes to die.

MEDICAL ADVANCES

Medical advances have made the physician's role very different today than it was thirty years ago. Most infections today can be controlled with antibiotics. Thirty years ago, when a streptococcus infection of an extremity was diagnosed, the patient was put to bed, the part elevated and wrapped in hot wet packs, and everyone prayed. There was nothing else to do. Today, in most instances, a few million units of a broad spectrum antibiotic and the patient is well on his way to recovery. The physician has drugs to raise or lower blood pressure, increase or decrease urine output, put people to sleep or wake them up. Unfortunately for us, many people aware of what can be done, will not accept what cannot be done, and are critical of failures.

Not only drugs and life sustaining hormones, but complicated machines and plastics, are in daily use. Arteries can be replaced with plastic grafts. Diseased heart valves can be cut out and replaced by plastic valves. When a heart beats too slowly or irregularly, a catheter can be inserted into an arm vein and passed down into the heart chamber, and the heart rate controlled by a pacemaker. For a chronic condition, a battery-powered pacemaker can be surgically attached to the heart and the whole mechanism buried under the skin. Electrodes plaeed on the spinal cord can be stimulated to control certain pain mechanisms, and electrodes in the brain can be stimulated to alter emotion and behavior. All these advances give the physician the ability to alter life, and some have the complete capability of maintaining life. The critical decision then becomes: when should such capabilities be used?

The problem can best be illustrated by the patient with a severe head injury. This usually is due to a fall or vehicle accident. Such a patient is typically brought to an emergency room, and studies are done to be sure there is no surgery indicated. The patient is unconscious, with dilated pupils which do not react to light. He does not respond to painful stimuli, and he has no reflexes. Appropriate drugs are given to reduce brain swelling, but if nothing works, breathing becomes irregular. If nothing further is done, breathing will stop from pressure on the brain stem and lack of oxygen, the patient will turn blue, and soon the heart beat will get slower and weaker and gradually stop. This is not a sudden process. It requires an electrocardiogram to decide exactly when all electrical activity in the heart has ceased. If a plastic tube is inserted into the lungs before the heart stops and a respirator forces air intermittently into the lungs, the heart beat will pick up, and this state can sometimes be maintained for several days. The brain is dead, but the machine is maintaining breathing and as long as the blood is oxygenated the heart will continue to function. The question is, "when is the patient dead?" When, or how long, should extraordinary means be used to postpone death? When is it justified to withhold treatment? Life was simpler thirty years ago. Such a patient described above fits the criteria of "cerebral death."

URINARY DIALYSIS

Another medical advance which bears on our discussion is the development of the artificial kidney. This fascinating story started with Dr. William J. Kolff of Holland, who started his work under Nazi occupation in the early 1940's. Dr. Kolff visited Boston in 1947 and from his blueprints a new artificial rotating kidney was constructed at the Peter Bent Brigham Hospital. Many modifications have been made. The device today consists of a semipermeable membrane tube bathed in a solution. The patient's blood, containing waste products of metabolism when passed through the tube, loses its waste products to the bath solution outside. Patients with diseased kid-

neys which cannot sustain life are kept alive in Honolulu today by sueh dialysis treatments. They live at home, are taught self-care, and spend only a matter of a few hours per week at the hospital getting their treatments.

These patients, prior to this method of treatment, would be dead. This is a medieal advanee which has required responsible eommittees to deevelop criteria to deeide who shall be eligible for treatment and who shall not. In talking with the St. Franeis group, I am told a eommittee makes a dceision based on the patient's ability to eomprehend the proeedure and the absenee of significant disease of other body systems. Sueh a committee is plaeed in the position of deeiding for these patients who shall live, and who shall die.

TRANSPLANTS

The medieal advanee whieh really preeipitated world wide diseussion, eontroversy, and the rapid development of the eoncept of eerebral death was the dramatic annouueement on Deeember 3, 1967, that Dr. Christiaan Barnard, a South Afriean surgeon at Groote Sehuur Hospital, had sueeessfully replaced the damaged heart of a 53-year-old man with the heart of a 25-year-old woman who had irreversible brain damage from an aeident. Some understanding of the medical problems of tissue transplantation should be helpful to our diseussion. Anyone interested in this partieular subject would enjoy the little book entitled "Give and Take," by Dr. Franeis D. Moore, Professor of Surgery, Harvard Medieal Sehool.[2] The idea of transplanting healthy organs from man to man has intrigued surgeons for years but the problems are enormous. It was learned early that some tissues whieh are mainly supporting struetures like arteries, veins, tendons, and the eornea, the transparent front part of the eye, ean be grafted much more easily than organs whieh have cells whieh live and breathe and require blood supply through established ehannels. It has been known for a long time that the surfaee layers of skin could be grafted as free grafts from one part of one's body to another, but that untreated tissue from one person could not be transferred to another person. The closer the relationship of the donor to the recipient, the more likely that a tissue graft will live. In identieal twins, the ehanees of suecess are good.

To try to understand heart transplants, some baekground of kidney transplants may be helpful. Onee the artificial kidney was developed, patients with fatal kidney disease eould be kept alive by repeated dialysis, but this necessitated repeated hospitalizations and the eonstant threat of eomplications from infeetion from the shunts where the artifieial kidney had to be conneeted to the patient's artery and vein. These patients who could be kept alive with artifieial kidneys were ideal candidates for transplants of normal kidneys if the problems could be overeome.

Through a long eourse of metieulous research and trial and error, kidney transplants are now a recognized method of treating certain kidney disorders. The first successful kidney transplants

Where Do We Go From Here?

Since presentation of the essay "Changing Concepts of Death," many people have asked me to write a statement they eould sign, because they believed in the coneept of death with dignity. No one has expressed disapproval. In my naivete I suggested such a statement to legal eounsel, and he pointed out various possible problem areas in family and physician relationships. He felt sueh a statement would have no legal effect, and he advised against "earrying the philosophy of the essay into a proposal for aetion."

It appears, then, two eourses are open: one, to press for passage of legislation similar to the proposal by Dr. Saekett of Florida, advocated by Mr. Brill in his note "Death with Dignity"; or for the individual who believes this way, after discussion with his family and advisors, to record his wishes in his own words, hopefully to make his last days easier for his family and allow his physician of the moment to respeet his wishes.

I suspect that the time for some solution to this problem is here and now, and that clients will ask help of their attorneys to have their wishes respeeted; or perhaps legislation is needed. Possibly if there is enough interest, this could be a matter for our joint medieal legal eommittee. I am not interested in being a crusader. I am interested in easing the problems of our patients and their families during their last days with us, and in trying to earry out the last wishes of our patients.

JOHN J. LOWREY

were between identical twins. Later, through the use of x-ray therapy and then various immunosuppressive drugs, the body's defense to foreign tissue was suppressed so organs from one individual could be grafted into other compatible individuals. The length of time that a piece of tissue or organ can remain alive after severance from the donor until grafted into the recipient varies a great deal with the type of tissue, its blood supply and its metabolism. Finger and toe nails even continue to grow briefly after a person dies, but at the other extreme, the brain requires so much oxygen by way of the blood that it will die if completely deprived of oxygen for as little as five to ten minutes, unless it is cooled. For this and many other reasons, it seems inconceivable that the brain will ever be satisfactorily transplanted.

Successful organ transplants require the availability of a healthy donor organ at the specific time the recipient needs it. If the donor organ is a paired organ like the kidney, one can be taken and the donor survive. But, if it is a heart, the donor will die. Dr. Moore, commenting on the possibility of heart transplantation in 1964, said only, "A heart transplanted from one dog to another can be made to resume its beat for a time," and "homotransplantation of the heart is one of the surgical fields actively under study in many centers today."[2] The first heart transplant in man was done in 1967, and within a year 87 had been attempted. Since November, 1968, the number attempted steadily declined except for a flurry of ten operations in April, 1969.[3] It was heart transplants and new resuscitation methods which really made everyone question the old concept of death. If viable donor hearts were to be available for heart transplants, it was necessary to somehow declare a person dead before his heart was so dead that it could not be revived.

CEREBRAL DEATH

In response to the need, an ad hoc committee of the Harvard Medical School to examine the definition of brain death was set up and its report was published in the *Journal of the American Medical Association,* August 5, 1968.[4] The object of the Committee can best be given in its own words and I quote:

> Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is need for a definition: 1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on the patients who suffer permanent loss of intellect, on their families, on the hospital and on those in need of hospital beds already occupied by these comatose patients. 2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplants.

This committee went on to define the characteristics of a permanently nonfunctioning brain and listed four criteria with an explanation of each. The four criteria follow. Since the committee's explanation of criteria were detailed they are shortened for our purposes.

1. Unreceptivity and unresponsitivity, meaning no response of any kind could be ellicited from the patient regardless of the stimulus, etc.
2. No movements or breathing, meaning no movement over an hour's observation, and if the patient is on a respirator, no spontaneous effort at breathing with the respirator off for three minutes, etc.
3. No reflexes of any kind either of the pupils to light, tendons to tapping, and so forth.
4. Flat electroencephalograms under rigid criteria for testing. An electroencephalogram or EEG is a sensitive instrument which measures electrical activity in the brain by producing a wavy line. The tracing becomes a flat line when the brain dies.

The committee recommends that when the above criteria for irreversible coma are met, the family, all involved physicians and nurses should be informed. They recommend that death is to be declared and then the respirator is to be turned off.

The committee went on to make a legal commentary that, "the law in the United States in all fifty states and in the Federal courts treats the question of human death as a question of fact to be decided in every case." The report says further, "in the few modern court decisions involving a definition of death, the courts have used the concept of the total cessation of all vital signs." The committee quotes Black's Law Dictionary (Fourth edition, 1951) defining death as:

> The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of blood, and a cessation of the animal and vital functions consequent thereupon such as respiration; pulsation, etc.

Court cases were noted where the issue involved which one of two persons died first. In one case where a husband and wife were injured in the same accident, the husband was dead at the scene. His wife died at the hospital seventeen days later. She remained in coma until her death. The petitioner in court argued that the couple died simultaneously. The Supreme Court of Arkansas in 1957 rejected the argument, as the concept of "cerebral death" was not accepted at that time.

The Ad Hoc Committee writing in 1968 said, ". . . we suggest that medical opinion is ready to adopt new criteria for pronouncing death to have occurred in an individual sustaining irreversible coma as a result of permanent brain damage." The committee later suggested, "decision to declare the person dead and then to turn off the respirator be made by physicians not involved in any later effort to transplant organs or tissue from the deceased individual."

LEGAL AND LEGISLATIVE

It seems that more people are dissatisfied with the old idea that a live person is one whose heart is beating and that everything should always be done to keep the heart beating as long as possible. Professor Dowd of Villanova Law School summarized the feelings of the participants in a symposium on the "Medical, Moral and Legal Implications of Recent Medical Advances" in 1968 by writing as follows:

> All seemed agreed that the concept of death was no mere mechanical determination, but was a profound reflection of the concept of life and the duty to sustain life.[5]

Justice Burger has said, "The law always lags behind the most advanced thinking in every area. It must wait until the theologians and the moral leaders and events have created some common ground, some consensus."[6]

In view of that statement, it is interesting to find that Kansas in 1970 has already passed a law which provides alternative definitions of death.[7] The first definition is the classical absence of spontaneous respiratory and cardiac function but goes further. The law also states when it is not necessary to attempt cardiopulmonary resuscitation. In an alternative definition, the Kansas law says that "a person shall be regarded as medically and legally dead if in the opinion of a physician based on ordinary standards of medical practice, there is absence of spontaneous brain function: and if based on ordinary standards of medical practice during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of a foresaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide." The law provides that death is to be pronounced before artificial means of supportive respiratory and circulatory function are terminated and before any vital organ is removed for purposes of transplantation.

This law, while expressly providing viable heart transplantation, also makes possible the discontinuing of "mechanical life maintenance" measures without legal complications.

UNIFORM ANATOMICAL GIFT ACT

The 1969 Hawaii Legislature passed a Uniform Anatomical Gift Act which describes the medical and research use of bodies. This act among other things lists who may execute such an anatomical gift, starting with the individual and then listing the spouse and adult son or daughter and so forth. The Act goes on to say:

> The persons authorized by subsection (B) may make the gift after or immediately before death.

Persons who may become donees are specified. A gift of all or part of the body may be made by will and the gift becomes effective upon death of the testator without waiting for probate. The gift may be made by document other than a will, such as a card carried by the donor carrying his signature and those of two witnesses.

As some of you may know, the Makana Foundation has been set up here in Hawaii to supply information to any prospective donors. A brochure contributed by Hawaiian Insurance Companies has been published. The Blood Bank of Hawaii as a public service will keep a file of persons willing to be donors.

The Uniform Anatomical Gift Act goes on to say:

> The time of death shall be determined by a physician who tends the donor at his death, or, if none, the physician who certifies the death. The physician shall not participate in the procedures for removing or transplanting a part.

The act protects a person acting in good faith under this act from being sued for damages or prosecution in any criminal proceedings from his act.

RIGHT TO REFUSE TREATMENT

Another legal matter we must consider is the right to refuse treatment. Daniel J. Davis writing in the Journal of Family Law on "The Dying Patient, A Qualified Right to Refuse Treatment" has some remarks. He states:

> It is a fundamental American belief that if an act of a private citizen can in no way injure society or any third person, it is a right.[8]

Mr. Davis then quotes from a 1960 Kansas State case[9] which said,

> Anglo-American law starts with a premise of thorough going self-determination. It follows that each man is considered to be master of his own body and he may, if he be of sound mind, expressly prohibit the performance of life saving surgery . . .

If one can expressly prohibit life saving surgery on himself, certainly he should be able to

suggest to his family, friends, and physicians when to leave him alone. There is no conceivable way that I can see for this to harm the public interest.

DEATH WITH DIGNITY

Walter J. Sackett, Jr., M.D., a physician legislator of Florida, has tried every year since 1967 to gain approval for a proposal that would allow every person to "have the right to death with dignity, and that his life shall not be prolonged beyond the point of meaningful existence."[10] This proposal is examined by Howard W. Brill in a note entitled "Death with Dignity, A Recommendation for Statutory Change" in the University of Florida Law Review, winter of 1970.[11] Mr. Brill states that, "The proposal now provides that any person may execute with the formalities required for execution of a will, a document stating that he has exercised the right to die with dignity and directing that his life not be prolonged 'beyond the point of a meaningful existence.' Upon a determination by the attending physician that the patient's condition was hopeless and that he was beyond recovery, the patient's directive would be carried out by terminating all medication and any artificial means of sustaining life. If the patient were physically or mentally incapable of making such decision, then the spouse or in the case of an unmarried or widowed individual, a majority of those persons of first degree kinship would be permitted to request the cessation of treatment when it was unnaturally prolonging an unmeaningful existence. Finally, in the case of a patient incapable of making a decision and without relatives, three doctors would be permitted to make the request to a circuit judge. In each case, before any treatment was terminated, the doctors would have the responsibility of determining from a medical standpoint whether all meaningful life had passed. With the exception of the last situation, this determination could only occur if the patient or his next of kin had affirmatively indicated a desire for the cessation of treatment."

Mr. Brill in his note goes on to examine various aspects of the present law. He cites many cases where criminal law does not accept humanitarian motives as a defense to homicide. In these cases, physicians committed acts. If death occurs because a physician fails to act and allows death to occur, he suggests that this theoretically would subject the doctor to criminal liability but says, "a statutory adoption of the death with dignity concept would grant a doctor in this situation, legal immunity for ending supportive therapy if all the requirements of the statute had been met."

Mr. Brill then discusses the need for a statute and states that some feel it is unnecessary. He states that,

> The New York position is that a person who is mentally competent may refuse medically necessary treatment on non-religious grounds.[12]

He suggests that if such statutes were enacted,

> "... the major result would be to grant doctors the legal assurance to permit an incurably ill patient to expire naturally" and further "... would give dying patients the foreknowledge and assurance that they need not continue to live in the twilight zone between life and death when all hope is gone, but that they could if they so desired come to a natural and peaceful end."

Mr. Brill concludes his note by saying,

> Recognizing that man wishes a voice in the quality of *his* life and the nature of *his* death, government should step back from the area and allow those who wish to avail themselves of the statute, to die according to their own standards of dignity and peace.

To me, writing a statute may be helpful for its educational and publicity value, but this is a very personal matter. It is a matter to be discussed between husband and wife, patient and physician, a minister and his parishioner, a lawyer and his client. The occasion will vary but preferably the statement should be written early when the individual is well and should be as routine as making a will.

MORAL CONSIDERATIONS

Thomas A. Wassmer, Professor of Moral Philosophy, Ohio University, writing on "Ethical and Moral Issues Involved in Recent Medical Advances" writes,

> When Arthur Hugh Clough wrote in his ironical version of modern man's decalogue: "Thou shalt not kill; but need'st not strive officiously to keep alive," he was unintentionally but accurately stating a principle which has a correct moral and ethical application. No man may lawfully hasten his own death or another's death by direct means, but he is not bound to resist the natural approach of death as though it were the supreme evil, and if, when ordinary means of resistance have failed, he chooses to yield, it appears unwarrantably officious on the part of the doctor to prolong the struggle, especially a futile struggle by extraordinary means. It is therefore a question of determining the will of the patient.[13]

There is no question physicians, patients and their families, if they stop and ponder these questions, will be guided by their entire background and training as to what is life and their idea of the quality of life. And we should respect without argument whatever this may be. There are times when everyone needs a trusted friend to put the problem in focus. For some, you maintain respirations and heart beat until the matter is taken out of your hands. For others, it is justifiable to stop treatment. The question is when? Dr. Wass-

mer writing of the physician who is unable to aeeept irreversible brain damage and therefore never discontinues treatment, says,

> This attitude should be respected because it gives the widest birth to euthanasia; it completely avoids anything like defeatism; it is easiest on the conscience of the physician. There are disadvantages to such an attitude and they should be honestly confronted. The principal one is that it creates the impression that physical existence of whatever quality, even a prolonged vegetative life with no reasonable promise of a return to rational consciousness is valued by everyone in exactly the same way. Death is looked upon as the greatest evil—a strange attitude to be adopted by patients who are convinced of an afterlife.[14]

And so the arguments will continue. The concept of "eerebral death" as a new criterion by which treatment may be discontinued has its problems too. Dr. Ralph B. Potter, Jr., Assistant Professor of Social Ethics, Harvard Divinity School, writing about being able to discontinue treatment once irreversible coma has set in, has this to say,

> The crucial intellectual "move" is analogous in form and effect to the reasoning employed by those who ground their assertion that abortion is not a serious moral problem in the assumption that fetal life is not truly human life. By excluding certain forms of existence from the realm in which the principle that "life is to be sustained" is presumed to have effect, it seems possible to affirm the principle by escaping the inconvenience anticipated by its strenuous application.[15]

That may be a rather complicated way of making a point, but I think it gets the idea across.

LIFE INSURANCE

There are a few other thoughts that may have come to your minds. Wondering what the attitude of life insurance carriers would be to a client who asked that his life not be prolonged if he became incompetent and helpless, I wrote to Aetna, New England Mutual and the Prudential Insurance Companies. One writer replied that most policies contained a provision which limits liability if an insured commits suicide within the first two years of a policy, but he did not think the suicide provision would apply. He would need specific circumstances to comment further. The Medical Director of one company wrote that he had discussed my query with the legal department of his company. These attorneys had never heard of such a statement being written and did not know whether the courts would construe such a letter as an indication of suicide or not.

ECONOMICS

Many I am sure feel that economics has no place in such a discussion as this but with the skyrocketing costs of medical care and with medical care a social right, somewhere, somehow even in this wealthy nation, some very hard decisions on health priorities will have to be made now. We have reached the point where so much money is being spent for the care of the chronically ill in nursing homes that there may not be sufficient funds for other programs. The time is here when priorities must be established for the health dollar. With beds in care homes and nursing homes full, discharges from acute care to extended care facilities are delayed and a shortage of acute care beds result.

Any intelligent person who has personally faced squarely the possibility of a prolonged bedridden existence when he has become incompetent, I feel would choose any alternative. No one by choice would become a burden to his family or the State. By choosing "death with dignity" under his own terms an individual can spare himself the dread of a meaningless existence, spare his family or the State the expense of his care, and if a shortage of beds is present, free a hospital bed for someone who might get well.

CONCLUSION

Most of the papers quoted in this essay were written since 1967. Kidney transplants are accepted therapeutic procedures today. Transplantation of the heart, a single unpaired organ, requiring the death of the donor, "shook up" man's thinking as have few other events that I can recall. The concept of "cerebral death" as a substitute for the cessation of heart beat and respirations as a definition of death, appeals to many interested in the quality of life rather than mere existence. Quality of life means awareness, responsiveness to others, and productivity. The right of an individual who chooses to die with dignity should be permitted. I believe the way to progress is for the individual who believes in this concept to discuss it with his family and advisors and record his wishes in writing. This act will make the future easier, happier, and kinder for him, his family, his pastor, his physician, his friends and attendants, the State and possibly even his attorneys.

REFERENCES

1. Statistical Report, Department of Health State of Hawaii.
2. Moore FD: Give and Take, Saunders, 1964.
3. *Medical World News,* 1969, p. 14.
4. JAMA, 1968, Vol. 25, No. 6.
5. Villanova Law Review, Vol. 13, No. 4, p. 732, 1968.
6. Burger: The Law and Medical Advances, 67, Annals of Int. Med., Supp., 1967, at 17.
7. Hb 1961, Kansas, 1970, Schering, Legal Unif, Vol. 12, No. 8, 1970.
8. Davis DJ: "The Dying Patient: etc.," Journal of Family Law, Vol. 7, p. 644, 1947.
9. Nathanson vs. Kline: 186 Kansas 393, 406, 350, p. 21, 1093, 1104, (1960).
10. AMA News, 1970.
11. Brill HW: "Death with Dignity, etc.," University of Florida Law Review, Vol. XVII, p. 368, 1970.
12. Brill, HW: "Death with Dignity, etc.," University of Florida Law Review, Vol. XVII, p. 371, 1970.
13. Ibid #5.
14. Ibid #5, p. 770.
15. Ibid #5, p. 789.

Radical Mastectomy for Carcinoma of the Breast

The authors believe radical mastectomy—as they do it—is still potentially lifesaving in carcinoma of the breast.

C. M. BURGESS, M.D., and J. F. BALFOUR, M.D., *Honolulu*

Radical mastectomy for carcinoma of the breast has been abandoned by some surgeons. Others still do the operation, but doubt that it improves survival rates. This seems strange when we are dealing with cancer in a dependent organ—one easily examined and, most importantly, one which lends itself ideally to complete removal of organ, cancer, and regional nodes.

WE DO NOT attempt to judge the results of radical mastectomy carried out in the hands of others. This is a critical review of radical mastectomy as we do it. We believe we carry out as complete and meticulous an extirpation of breast cancer and regional nodes as it is humanly possible to achieve. We remove the internal mammary lymph node chain through a vertical incision through the costal cartilages whenever axillary nodes are positive with a medially placed lesion, or if the lesion is large or fixed. Figure 1 shows the extent of the surgery and method of opening the chest.

If this painstaking, time-consuming, and occasionally (but rarely) crippling operation is of no avail, then a carefully followed series such as ours should reveal this fact. Conversely, if the operation is effective, then this fact too should become apparent.

X-ray therapy to the operative site and axilla was discontinued by us about 15 years ago when this lack of local recurrence first became apparent.

That our operation removes the local disease is supported by the fact that local recurrence (without generalized metastasis) has occurred only once, eight years after the operation, in 260 patients so treated.

The 260 patients in this study subjected to radical mastectomy were followed from five to 34 years after surgery. Patients with bilateral disease were counted as one patient, and dated from the first radical resection. Twenty-seven additional patients similarly treated were lost to followup, or died within five years of other causes, and were therefore excluded from the series. The operations were carried out as curative procedures, and are consecutive, except for the ones excluded. There has been no sorting as to grade or stage of the disease. No patient without demonstrable spread beyond the breast and axilla was denied surgery, even though, in some, ulceration, enlarged axillary nodes, and skin attachment were present. However, no patient whose cancer was known to have spread beyond the operative area was subjected to radical mastectomy.

Straub Clinic, Honolulu, Hawaii.
Received for publication November, 1970.

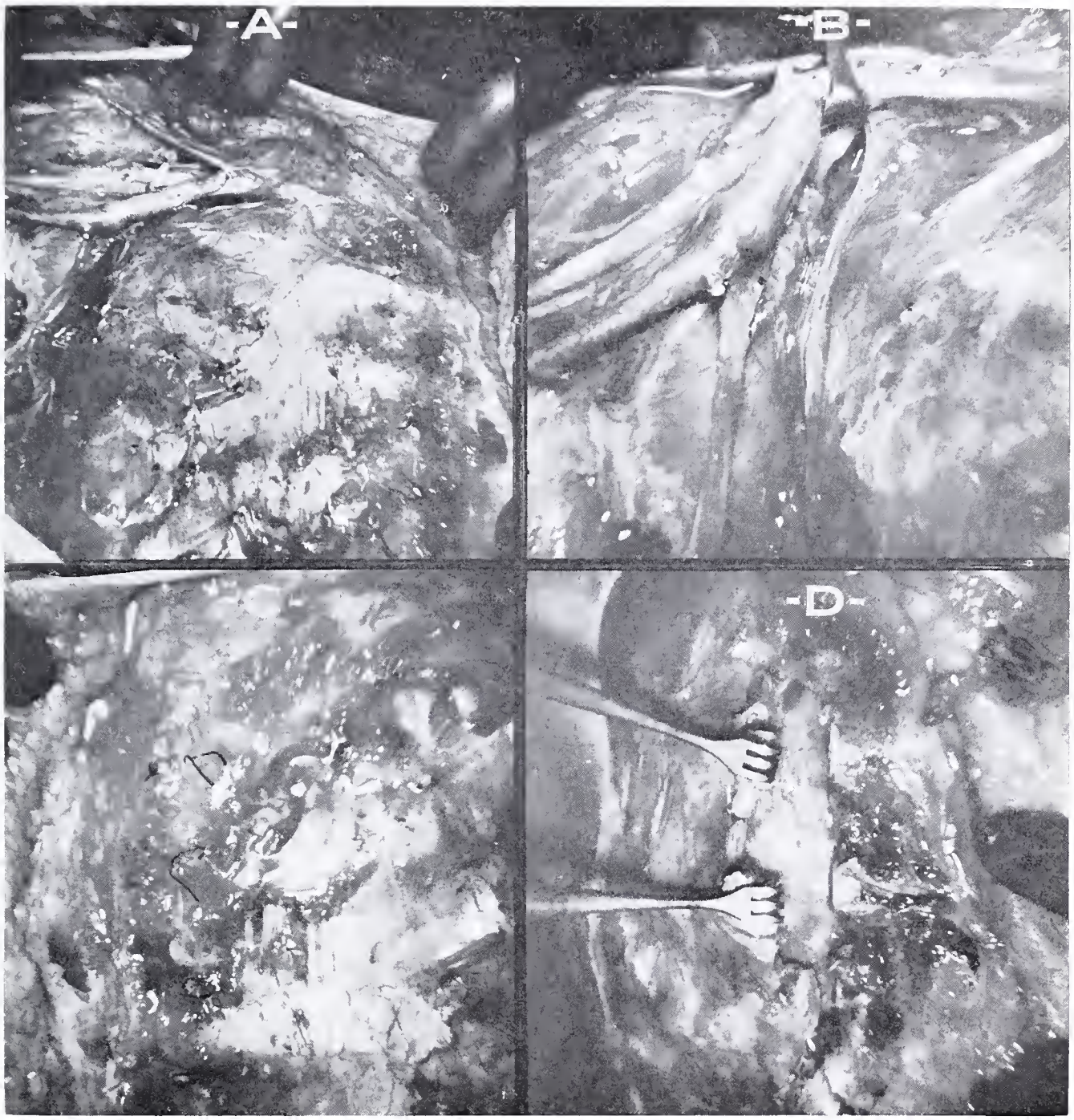


FIG. 1—*A. The operation is bounded above by the clavicle, medially by the sternal midline, below by the abdominal muscle, and laterally by the edge of the lattisimus dorsi. B shows removal of all adipose tissue above, below, behind and among the brachial vessels and nerves. C shows long ligatures left as guides on the perforating branches of the internal mammary vessels. D shows the intact bare pleura after removal of the internal mammary vessels and lymphatics.*

The patients studied are from a relatively isolated community, and from various ethnic groups and racial-ethnic mixtures. They have been closely followed. The surgery was done by four different surgeons, using essentially the same technique. Ninety percent of the patients operated upon during the last ten-year period were treated by one of us (CMB). There was no operative mortality. We do not expect, and rarely see, morbidity, disability, or weakness of the arm (Fig. 2-A).

For study, the patients are divided into those who had lymph node involvement and those who did not (Fig. 3-A). The results in 124 patients without lymph node involvement are shown in



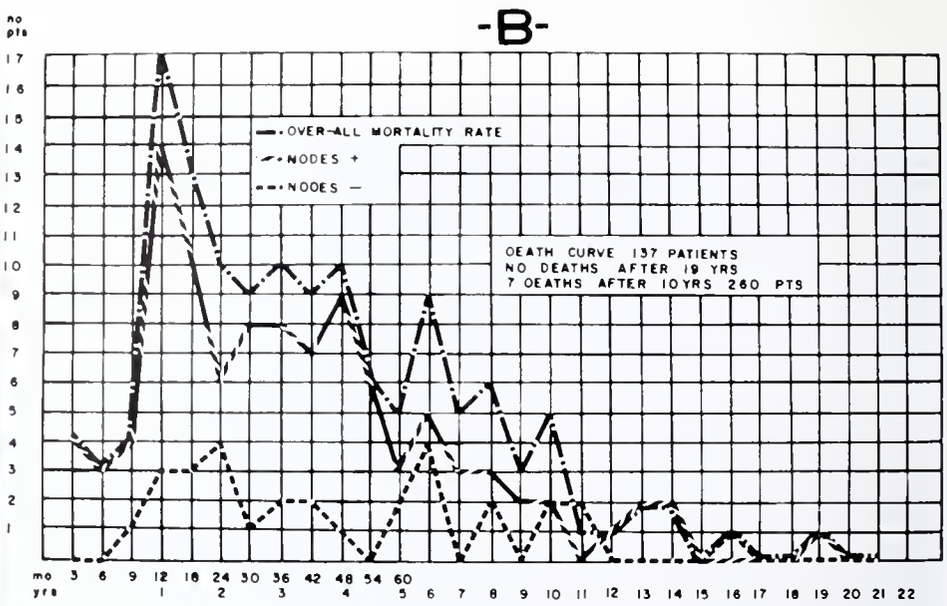


FIG. 2—*A. Minimal edema and complete function of the arm and complete removal of subcutaneous tissue.*

FIG. 2—*B. The death curve is self-explanatory. In our series, it indicates that a lapse of ten years is necessary to judge the influence of treatment.*

-A-

Total number of patients		260
Excluded from series		27
Patients who died of other cause before 5 years		10
Lost to follow up		17
Nodes + 136 Nodes — 124		
5 years survival	166	63.9%
10 years survival	88	34.0%

-B-

BILATERAL DISEASE

19 Patients

SURVIVED 5 - 30 + years

	Total	Nodes —	Nodes +
5 - 9+ years	4	3	1
10 - 14+ years	1	0	1
15 - 19+ years	3	0	3
Living with Metastasis	1	10+ years	
Total	9		

DIED

0 - 4+ years	7	2	5
5 - 9+ years	2	0	2
10 - 19+ years	1	0	1
Total	10	2	8

-C-

Survival 5 to 34 years

	Nodes —
5 - 9 years	41
10 - 14 years	26
15 - 19 years	19
20 - 24 years	4
25 - 30 + years	4
Total	94 - 75.8%

-D-

Survival 5 to 34 years

	Nodes +
5 - 9 years	11
10 - 14 years	9
15 - 19 years	4
20 - 24 years	4
25 - 30 + years	1
Total	29 - 21.3%

FIG. 3—*A, B, C, and D are self-explanatory. The significant figure is the 21.3% of patients who survived even though cancer had spread beyond the breast.*

Fig. 3-C. The most important finding is the fact that 75.8% have survived from five to 36 years. It cannot be denied that some of these patients could have been "cured" by simple mastectomy, but whether nodes are involved or not can only be determined by a complete examination of all nodes removed. From eight to 36 nodes have been recovered for study in our patients. It is almost impossible to examine all nodes in a specimen.

The value of radical mastectomy should be most apparent when the treated disease is no longer confined to the breast. Figure 3-D is a tabulation of our study of 136 patients with one or more axillary nodes involved with metastatic cancer. We find that 21.3% of these patients with node involvement are still alive after five years. An additional nine patients (8.5%) survived from 10 to 19 years—average 12.2 years. Sixteen (11.7%) survived from 5 to 10 years—average 7.2 years. Although these 25 patients finally died of their disease, we believe they were definitely more comfortable and died a less painful death than those who died with disabling arm edema and axillary ulceration, which in our hands and in the hands of others have so often followed simple mastectomy and irradiation in the treatment of patients with positive axillary nodes. In no case did disabling arm edema or ulceration in the operative area occur in patients who had not received x-ray treatment to the operative area. These did occur in the only two who had. Figure 3-B shows the results in bilateral disease.

Almost all of the patients with positive nodes who are surviving free of cancer ten or more years after surgery would probably now be dead if any other form of treatment had been used instead of radical mastectomy. We do not believe that any method except extirpation can be relied on to sterilize metastatic breast cancer. We have no adequate way of judging other forms of treatment, since the time that these methods have been employed has been too short. Five-year survival is probably significant in evaluating treatment of cancer of the breast, but it takes ten or more years to properly judge the effectiveness of any treatment. This is borne out by the fact that only seven patients died of cancer after surviving ten years (Fig. 2-B). Only one patient without nodal involvement died after 12 years.

CONCLUSION

In our opinion, radical mastectomy is still the method of choice in treating carcinoma of the breast without general metastasis. A 21.3% salvage rate in patients with metastasis cannot be ignored by surgeons who advocate less radical procedures. We can hope for new methods of diagnosis and detection of metastasis so that we may avoid subjecting patients with already disseminated but still undetectable cancer to mutilating and useless surgery.

"The more extensive a man's knowledge
of what has been done,
the greater will be his power of knowing
what to do."

DISRAELI

A Toxicologic View of Marijuana

Marijuana is acutely, and probably chronically, toxic.
Its potential dangers need further investigation.

LOUIS J. CASARETT, Ph.D., and RANDALL C. BASELT, B.S., *Honolulu*

Some toxicologic features of marijuana have been examined with respect to available data and principles of toxicology customarily used for predicting the impact of a chemical on individuals and on populations. In the present state of toxicologic knowledge of marijuana, several conclusions can be drawn. The active ingredients clearly have a partially defined low-grade acute toxicity which is related to the customary usage. There is reasonable evidence pointing to a probability of chronic toxicity and a dangerous acute toxicity for some individuals of the population, who cannot clearly be identified prior to use. A variety of pharmacologic features point to a complexity of action and interaction with other chemicals, which require answers. The data support skepticism about claims that marijuana is innocuous and suggest biomedical caution.

THROUGH the cacophony surrounding the social poison, marijuana, one may view a pair of seemingly paradoxical characteristics of opinion. One of these is the marked and fixed polarity between those who view marijuana as part of the devil's caldron, properly subject to the full weight of the law, and those who consider the drug relatively innocuous, if not beneficial. Somewhat less apparent but nonetheless real is an oscillation of views about marijuana, a process which derives its impetus from reiteration of popular versions of old or new myths. The biomedical community is not without susceptibility to the polarity or to the vacillation.

At the outset, one should remove from consideration several elements which are extraneous to the theme under consideration. First and most clearly, the panic reaction leading to the Marijuana Tax Stamp Act and the enhanced repressive measures over the years are not consonant with the pharmacologic and toxicologic facts. That is, marijuana cannot be considered as dangerous to self or society as the drugs with which it has been lumped under the law. Secondly, the inclusion of marijuana with narcotics is a permissible redefinition under a legal system but leads to considerable irrelevant argument because the definition is at odds with virtually all acceptable pharmacologic definitions. (Puristically, the derivation from the Greek "nark(e)" decrees that a narcotic be a central nervous system depressant tending to produce stupor or sleep.[1])

Finally, no amount of wishful thinking can obscure the fact that the ingredients of Cannabis sativa constitute a potent drug. As such it has pharmacologic actions and is, or should be, subject to toxicologic evaluation. Some of the biomedical uncertainty about the material stems from the pitifully small amount of well-controlled research for such an evaluation.

The lack of specific information is not an adequate basis for a "cop-out." In government, in industry and in medical practice, judgments are rendered on hundreds, perhaps thousands of compounds yearly. Most frequently the judgments are made, not on clearly defined incontrovertible evidence but rather by application of sound toxicologic principles, full use of experiential data and a comparison of relative benefit and probable risk. Important elements in such judgments are (a) as in all of science, at least a modicum of skepticism, and (b) in matters pertaining to public health, a measure of pessimism.

From the Dept. of Pharmacology, University of Hawaii School of Medicine.
Received for publication October 26, 1970.

Much of the literature on marijuana is charged with emotionalism but there are many balanced reviews which provide sources to the original literature. One of the most recent of such reviews is that of Pillard.[2] Eschewing the emotional content of the evaluation of marijuana, an attempt has been made in this paper to view it as an unknown drug. Treating available information as though it were part of an application for introduction of a new drug permits a perspective which, while limited, is nonetheless informative. A highly selected group of facets about the effects of marijuana are presented below as viewed through a background and training in toxicology.

PHARMACOKINETICS

Dose: In evaluating any new drug one must pose questions about the customary dose, the route of administration, the changes of blood level with time, peak blood concentration, duration of effect, consistency of the dose-response relationship, metabolism and the activity of metabolites and other similar questions. Attempts to answer these questions in relation to marijuana are revealing when, indeed, data are available.

Dosage is exceedingly difficult to control. Part of this difficulty arises from the use of inhalation as the most common route of administration; this route represents special problems in assessing dosage of most materials.[3] The form of the drug (natural plant material) creates such variations as the identity and amount of active ingredient in the plant, the concentration in the mainstream smoke, the depth of penetration and absorption in the respiratory tract depending on the pattern of smoking and others. Some of these variations are also applicable to extracts of the active ingredients and additional variants may be cited for extracts such as the extraction solvents used, alternate routes of administration and the like.

One might argue that ready availability of marijuana would permit rectification of many of these variables of dosage. Although such a thought provides some measure of comfort it is belied by the facts as pointed out by Farnsworth.[4] The complexities of the constitution of the plant, instability of active ingredients, unknowns about effects — these and other uncertainties preclude early, easy "product quality control" unless some unforeseen breakthrough occurs soon.

Persistence of Drug: One particular pharmacokinetic feature will serve as an example of data inciting to toxicologic suspicion. Agurell *et al*[5,6] have examined the distribution and excretion of the major active constituent of marijuana, △1-tetrahydrocannabinol, (△1-THC) after intravenous injection in rabbits and rats. Three days after administration, the rabbits had eliminated 60% of the dose, but significant amounts of the drug were still present in adipose tissue and spleen. In rats, approximately 50% of the dose was excreted over a period of seven days. In both species the △1-THC was eliminated as more polar metabolites, one of which (7-hydroxy-△1-THC) has recently been shown to have a marked activity in mice.[7]

The doses used in the rats was high (equivalent to about 10-15 "joints" in a 70 kg man) but the equivalent dosage in rabbits varied from 1 to 6 "joints." One should remember, in contrast with these figures, that customary doses (in animals or humans) produce a duration of effect rarely exceeding four to six hours. It is a toxicologic axiom that persistence of drug or products following a single dose makes chronic dosage suspect. Data such as those of Agurell *et al*[5-7] and others would raise the hackles of those charged with any new drug evaluation for which the data were available.

The data from animal studies has recently been confirmed in man by Lemberger *et al* who found that metabolites of △1-THC are excreted in urine and feces for more than eight days after a single administration.[8] This group also reported the plasma half-life of △1-THC as 57 hours in nonusers of marijuana, and an increased rate of metabolism of the compound in habitual marijuana smokers.[9]

Acute Toxicity: The acute toxicity of cannabinols extracted from marijuana as measured by animal lethality from parenteral administration is variable but for several species the lethal dose falls within a range which would place the compound in category 4, defined as "very toxic"[10] with a probable lethal dose in man of 50-500 mg/kg. For comparison, nicotine, the main active ingredient of tobacco, has a probable lethal dose of less than 5 mg/kg, rated as 6 or "super toxic." With marijuana, in the natural state, the toxicity, measured in terms of the amount of material necessary to produce death, would place it in a "slightly toxic" category—2—at most; tobacco, by comparison would be judged "very toxic" or category 4.

Lethal dosage may contribute to perspective but is remote from the question of customary usage. Acute toxicity, including lethality, cannot be ignored. Extracted THC can readily be injected in doses fatal to man and there is even a well documented case of a fatality from smoking marijuana.[11] Obviously, the drug is used to attain an effect. Aside from several varieties of what Pillard lists as adverse reactions,[2] some of which are al-

luded to below, the chief acute effect sought is that of the "high." Although this is a highly personal and variegated state, the actions of the drug usually entail at least some degree of temporal disintegration[12] and often include a degree of depersonalization. These and other effects are on the one hand, the effects which are partly responsible for the "high" desired by the user, and on the other hand, may be considered to be low-grade, acute, essentially reversible toxic effects. With higher doses and/or more frequent doses one may expect an increasing probability of more pronounced, less quickly reversible effects of the same type which become indistinguishable from the psychotic episodes described as "adverse reactions."

Persistence of Effects: Just as one must view persistence of chemicals in the body as a cautionary signal, so persistence of effect from a single dose must invite caution. Obviously cumulative or chronic effects can be expected to result from accumulation of drug or products. For example, the detection by Scheckel *et al*[13] of measurable differences in performance of monkeys for several days after a single dose may well relate to the relatively slow excretion of the drug and its products. Similarly, the accumulation of products in liver may be at the base of recent reports about possible liver damage from chronic use.[14]

One example deserves special mention. It is clear that dilation of vessels of the eye occurs with a single dose and with chronic use. This is a pharmacologic response, not due to the external application of the smoke, and it is well known[15] that the dilation persists beyond the usual period of "high." This effect from a single dose or smoking episode can be viewed as a low grade response of the intima of the vessels, similar to the "arteritis" reported in chronic users.[16] Whether this effect will ultimately be considered of great significance is immaterial in the present context; the action of cannabis on the vasculature is certainly open to question. One logically would invoke another toxicologic axiom, viz., if the effect of a single dose persists beyond the time of probable dosage interval, one must suspect that the affected system will ultimately manifest chronic effects.

Contributory effects: As with any new drug, one examines its relationship to other drugs and facets of human health in the population. Two examples will serve. One of these is the simple consideration of marijuana as another respiratory toxicant. The complex events in the respiratory tract in response to environmental toxicants include nonspecific insults.[3,17] One has only to recognize cigarette smoking and high concentrations of air pollutants as contributory to pulmonary emphysema and lung cancer to reach the conclusion that addition of still another irritant mixture of ingredients from a partly combusted natural product will fall into the same category.

Aside from the physical type of example one must view the population response to the psychic or mental effects. As a "new drug" there appears to be ample evidence[18] that the drug produces, at very least, an appreciable precipitation of psychotic episodes and that such occurrences are more likely to appear in younger or already maladjusted individuals. If this were not enough, there is also evidence, that with high doses, and under stressful circumstances, full psychotic episodes of several days' duration can occur on first use by individuals known not to have history of previous psychotic problems.[19]

Synergistic Effects: Marijuana, no less than other materials is to be considered in relation to its interaction with effects of other compounds. Viewing it as a new drug, at least two mechanistically oriented questions are disturbing. Marijuana has been demonstrated in animals to potentiate (or at least be synergistic with) both amphetamines and barbiturates.[20-22] Such a dual synergism with two classes of compounds which are clearly stimulatory and depressant might presage complex interactions which are not fully predictable and not well enough understood for safety.

Such synergism is certainly not unknown among users and among those who have opportunities to treat and meet with users during adverse responses. Equally well known is a phenomenon of LSD "flashes" precipitated by marijuana. Such an event can occur with other stimulant drugs and circumstances and marijuana itself has been reported to be subject to flash-back episodes.[23] This sort of complex, almost mysterious interaction clearly illustrates the paucity of mechanistic understanding of the drug.

MALADAPTATION

One effect attributed to chronic marijuana use is described in a variety of ways and appears in what are now classical descriptions or drug dependency patterns.[24] The "maladaptation syndrome," the "amotivational syndrome," has features, of "drop-out," an apathetic relation to society, a loss of self identity and a loss of identity as part of society which extends to rejection. That these are *decisions* of the chronic user which are simply manifest in part by the drug use is a plausible contention on its face.

One highly significant area of research has not received prominent attention but, as with a review of a new drug, is subject to close scrutiny. It was discovered[20] but not reported until recently[25] that tetrahydrocannabinol in single or multiple doses produces an alteration of biogenic amines in the brain. Of chief interest is the fact that the changes are consonant with an increased level of dopamine which has been demonstrated both in animals and man to produce a unique kind of loss of aggression. Although much remains to be done in this area, there is a sufficient basis for suggesting that the "apathy" may not be entirely based on prior decision but may rather have a basis in the pharmacologic effects of chronic usage.

CONCLUDING COMMENTS

It should be readily apparent that the presentation above is highly selective and makes no pretense at coverage of the spectrum of components comprising the "problem"—legal, psychic, social, moral, ethical, and cultural. Rather, attention has been directed to a part of the limited area of toxicologic indices which can be gleaned from presently available data.

Other studies could have been cited, such as that of Forney and colleagues,[26] who have demonstrated cardiac effects of high doses of THC *in vitro* or current work demonstrating alteration in animal learning ability in offspring from mothers treated with marijuana. Other areas of still largely inadequate work might also have been discussed, such as that purporting to demonstrate teratogenic or genetic effects. Still more work on behavioral indices has been omitted as beyond the ken of the author. The few examples cited are sufficient to make the point intended. Although one would hope for more data of more definitive type, it is not true that "there are no data." Nor is it true that "there is no basis for suspecting chronic toxicity." Nor can one support the view, on any grounds, that lack of more information can be a basis for removal of regulations.

Comparisons of marijuana with other social poisons such as alcohol and tobacco are of considerable interest to comparative toxicology but are totally irrelevant to toxicologic assessment in the present context. (Most comparisons, as usually presented, are also toxicologically invalid.) It is recognized that benefit in relation to risk is an essential consideration. Some of the benefits extolled by users and proponents are dubious, at best. Furthermore, one is faced with the strange phenomenon of a willingness to accept "benefit" with no sound evidence either as to the absolute biomedical value or relative to other drugs in the face of a reluctance to accept evidence much more indicative of "hazard."

In the present state of knowledge, one must conclude (1) that the active ingredient(s) of marijuana are (like all effective pharmacologic agents) toxic; (2) that there is reasonable evidence pointing to a possibility of chronic toxicity, (3) that the material holds an acute toxicity dangerous to a significant segment of the population which cannot clearly be circumscribed; and (4) that there are toxicologic-pharmacologic features which demand explanation. The data support skepticism about the safety of the material and recommend biomedical caution.

REFERENCES

1. Taber CW: *Condensed Medical Dictionary,* 2nd edition, F. A. Davis Company, Philadelphia, 1949, pp N-1, N-2.
2. Pillard RC: Marihuana. *New Eng J Med* 283:294-303, 1970.
3. Casarett LJ: The Vital Sacs: Alveolar Clearance Mechanisms and Inhalation Toxicology. *Essays in Toxicology,* Vol. 3, F.R. Blood (Ed.), 1971 (in press).
4. Farnsworth NR: Pharmacognosy and Chemistry of Cannabis. *J Am Pharm Assoc* 9:410-415, 1969.
5. Agurell S, Nilsson IM, Ohlsson A and Sandberg F: Elimination of Tritium Labelled Cannabinols in the Rat with Special Reference to the Development of Tests for the Identification of Cannabis Users. *Biochem Pharmacol* 18:1195-1201, 1969.
6. Agurell S, Nilsson IM, Ohlsson A and Sandberg F: On the Metabolism of Titium-Labelled 1-Tetrahydrocannabinol in the Rabbit. *Biochem Pharmacol* 19:1333-1339, 1970.
7. Nilsson IM, Agurell S, Nilsson JLG, Ohlsson A, Sandberg F and Wahlquist M: △1-Tetrahydrocannabinol: Structure of a Major Metabolite. *Science* 168:1228-1229, 1970
8. Lemberger L, Silberstein SD, Axelrod J and Kopin IJ: Marihuana: Studies on the Disposition and Metabolism of Delta-9-Tetrahydrocannabinol in Man. *Science* 170:1320-1322, 1970.
9. Lemberger L, Tamarkin NR, Axelrod J and Kopin IJ: Delta-9-Tetrahydrocannabinol: Metabolism and Disposition in Long-term Marijuana Smokers. *Science* 173:72-74, 1971.
10. Gleason MN, Gosselin RE, Hodge HC and Smith RP: *Clinical Toxicology of Commercial Products,* Williams and Wilkins Company, Baltimore, 1969.
11. Heyndrickx A, Scheiris C and Schepens P: Toxicology Study of a Fatal Intoxication by Man Due to Cannabis Smoking. *J. Pharm Belg* 8:371-376, 1969.
12. Melges FT, Tinklenberg JR, Hollister LE and Gillespie HK: Marihuana and Temporal Disintegration. *Science* 168:1118-1120, 1970.
13. Scheckel CL, Boff E, Dohlem P and Smart T: Behavioral Effects in Monkeys of Rasemates of Two Biologically Active Marijuana Constituents. *Science* 160:1467, 1968.
14. Kew MC, Bersohn F and Siew S: Possible Hepatotoxicity of Cannabis. *Lancet* 578-579, 1969.
15. Chopra IC and Chopra RN: *Bull Narcot* 9:4, 1957.
16. Sterne J and Ducastaing C: *Arch Mal Coeur* 53-143, 1960.
17. Casarett LJ: Toxicology: The Respiratory Tract. *Ann Rev Pharmacol* 11, 425-446, 1971.
18. Weil AT: Adverse Reactions to Marihuana: Classification and Suggested Treatment. *New Eng J Med* 282:997-1000, 1970.
19. Talbott JA and Teague JW: Marihuana Psychosis. *JAMA* 210:299-302, 1969.
20. Dagirmanjian R and Boyd ES: Some Pharmacological Effects of Two Tetrahydrocannabinols. *J Pharm Exp Ther* 135:25-33, 1962.
21. Boyd ES, Hutchinson EO, Gardner LC and Meritt DA: Effects of Tetrahydrocannabinols and Other Drugs on Operant Behavior in Rats. *Arch Int Pharmacodyn Ther* 144:533-554, 1963.
22. Garriott JC, King LJ, Forney RB and Hughes FW: Effects of Some Tetrahydrocannabinols on Sleeping Time and Amphetamine Induced Hyperactivity in Mice. *Life Sci* 6:2110-2128, 1967.
23. Keeler MH, Reifler CB and Liptzin MB: Spontaneous Recurrence of Marihuana Effect. *Am J Psychiat* 125:384-386, 1968.
24. Eddy NB, Halback H, Isbell H and Seevers MH: Drug Dependence: Its Significance and Characteristics. *Bull Wld Hlth Org* 32:721-733, 1965.
25. Dagirmanjian R and Hodge HC: Are Biogenic Amines Involved in the Mechanism of Action of the Tetrahydrocannabinols? *Agents and Actions* 1:46-48, 1969.
26. Forney RB, et al: Cardiac Toxicity of THC. Reported at Society of Toxicology Meetings, Atlanta, Georgia, 1970.

The Conquest of Scurvy and the Discovery of Hawaii: An Ethnobotanical Triumph

Cook's awareness of how to prevent scurvy, no less than his seamanship, enabled him to discover Hawaii.

JAMES J. BALL, M.D., *Honolulu*

The eventual discovery of Hawaii by Captain James Cook depended as much upon the practical application of measures to overcome scurvy at sea as it did upon his particular genius for navigation, exploration, seamanship and cartography. The Spanish had been traversing the Pacific Ocean for over one hundred years before Cook, but at a different latitude from Hawaii. This route was dictated by the necessity of reaching the Marianas Islands before scurvy killed all aboard.

Cook, in preventing scurvy in his men, relied heavily upon botanical resources as he came across them in the Pacific. Hawaiian history is directly related to the use of these antiscorbutics derived from plants in both the British Isles and the Pacific and to the men who conceived and carried out this means of conquering scurvy. They did so in a manner that would be fully approved as properly scientific in modern times.

SCURVY as a clinical disease has been known and described from the campaigns of the Caesars, and as such, has exerted profound influences on many of the important battles and wars in recorded history, even into the 20th century. The earliest account of the outbreak of scurvy at sea, however, is that of Vasco da Gama in 1497 when he discovered a passage to the East Indies by way of the Cape of Good Hope.[1] The narratives of subsequent explorers, particularly those of Cartier and of Drake, are replete with descriptions of the ravages of scurvy. The expedition of Lord Anson in 1740 is commonly cited as a horrible example of the possible consequences of the disease; four out of five men of the British Fleet were lost from scurvy after four years at sea.

The prevention and treatment of this deficiency disease is usually given no more than a casual thought in modern medical practice. To appreciate the horror of scurvy, the occupational disease of the early explorer, one need only read what a member of Cartier's expedition to the Gulf of St. Lawrence wrote in 1536. "With such infection did this sickness (scurvy) spread itself in our three ships, that about the middle of February, of a hundred and tenne persons that we were, there were not tenne whole."[2] The greatest recorded loss in lives on any one ship, however, occurred in 1767 when an eastbound Spanish galleon was salvaged off Guatulco, south of Acapulco—all on board were dead.[3] Magellan, in the first crossing of the Pacific, sailed nearly 12,000 miles without sighting a single island where fresh fruits and vegetables could be obtained. Many of his men were stricken with scurvy, and his experience on this conquest of the Pacific Ocean undoubtedly delayed the discovery of Hawaii by as much as a hundred years. The path for the Spanish galleons crossing the Pacific thereafter was dictated by the known, inevitable appearance of scurvy and the need for maintaining a latitude which would bring the ships to the only known safe refuge, the Marianas Islands, which had been Magellan's salvation.

From the Nuclear Medicine Dept., Queen's Medical Center.
Received for publication December 5, 1970.

Cartier, in an attempt to find the cause and presumably some form of treatment of scurvy, had one of his dead men dissected to provide us with the first clinical description of the total extent of this disease.[4] He was unable to get any clue to proper treatment from the post-mortem examination; however, he wrote that the Indians' remedy, consisting of a brew from hemlock boughs, would cure the men who would take it. Cook used this experience to his advantage more than two hundred and thirty years later in his own aggressive approach to overcoming scurvy on his voyages. Cartier's directions were explicit and consisted of taking "the barke and leaves of the sayd tree, and boil them together, then to drink the sayd decoetion every day."

In 1617, the first English book on naval medicine, *The Surgeon's Mate,* appeared, written by Dr. John Woodall, a prominent surgeon. This book had a great vogue and for many years was the official manual used by surgeon's mates. Though the main portion of the book was devoted to the treatment of surgical problems, many shrewd observations were also made including that for the prevention and cure of scurvy, "The juyce of Lemons is a precious medicine and well tried being sound and good. Some Chirurgeons also give of this juyce daily to the men in health as a preservative, if they have store, otherwise it were best to keep it for need." Unfortunately, he also credited oil of vitriol and infusion of dried wormwood as having value, and later medical writers tended both to confuse the deficiency nature of scurvy and to emphasize the value of vinegar and elixir of vitriol to the exclusion of lemon juice. Vinegar and vitriol therefore became the drugs supplied to the Navy for many years.

It is of interest to note that Dr. John Hall, a prominent physician and William Shakespeare's son-in-law, was one of the first men to urge the use of antiscorbutics. In a book published in 1657 he described curing scurvy by means of brewing a beer or ale from "scorbutick hearbs, viz.; scurvy grass, water-cresses and brook lime."

Before dwelling on Dr. James Lind's classic treatise on the treatment and prevention of scurvy in the eighteenth century, let us skip ahead in history to 1800, when it was reported that the surgeon of the ship Albion attempted to cure scurvy by burying his patients up to their necks in earth; an example of the most primitive type of medicine. In 1875, a serious outbreak of scurvy occurred on HMS Alert and Discovery, which were then taking part in Arctic explorations. Their crews subsisted on salt provisions and reliance was placed entirely on lime juice to prevent scurvy. This led to disastrous results because of the rather low vitamin C content of lime juice compared to lemon juice. This experience did much to discredit the concept of scurvy as a deficiency disease. Even in the 20th century scurvy led to the tragic loss of Captain Scott and his tiny band of British Antarctic explorers trekking back from the South Pole.[5] This expedition carried only biscuits, chocolate, tea, butter and pemmican. Plenty of calories for energy—but no vitamin C to hold the tissues together.

The means for effectively combatting scurvy has been known for over 300 years, but the practical application of this knowledge has been erratic. The credit for forcing a general acceptance of the antiscorbutic value of fresh food belongs to Dr. James Lind in the mid–18th century, just in time to supply Cook with the advice he needed to conquer the disease. Lind even resorted to human experimentation to prove his contentions and reached practical conclusions by a true scientific method. In spite of Lind's classical work with documentation and sound recommendations in the cure and prevention of scurvy, and even in spite of Cook's total success in the application of Lind's teachings, the English Navy paid no attention until 1795, when the fleet suffered a severe epidemic of scurvy which was finally controlled through the use of fresh vegetables and fruit.

Lind emphasized the importance, for ships proceeding on long voyages, of carrying ample supplies of either the "rob" of lemons or the juice of oranges. He suggested that fresh leeks could be preserved in salt, and if kept in covered wooden dishes could retain their antiscorbutic properties for three months. Another suggestion he made was to grow water-cress in the hold of a ship by scattering the seeds over wet cotton or on blankets soaked in rainwater.

Lind was quite explicit in his directions for preparing and preserving foods for sea voyages, as the following extracts from his *Treatise on Scurvy* published in 1772 show:

> "*How to preserve berries and other fruits for long periods:* Most berries and several fruits, when gathered two-thirds ripe on a dry day, while the sun shines, if put into earthern pots or dry bottles, well corked and sealed up so that no air or moisture can enter, will keep a long time and at the end of a year will be as fresh as when pulled.
> *Method of preparing an antiscorbutic decoction from fir-tops, leaves, bark, etc.:* A simple decoction of the tops, cones, leaves or even green bark and wood of these trees is an excellent antiscorbutic medicine but it will become more so when fer-

mented as in making spruce beer. By carrying a few bags of spruce or its extract to sea, the drink can be prepared at any time. But when it cannot be had the common fir-tops used for fuel in the ship should first be boiled in water and the decoction afterwards fermented with molasses in the common method of making spruce beer. A small quantity of wormwood and horseradish root may be added to preserve fresh at sea."

Another reeommendation of Lind's that undoubtedly influenced Cook's voyages was that, "The juiee of the eoeoanut [sie] tree was experienced to be of very great benefit to several persons afflicted with the scurvy."

Lind was not a voice alone in his time though as David MacBride, an Irish physician, also attaeked the problem of seurvy on the dietary side in *Experimental Essays* published in 1764 and *Historical Account of the New Method of Treating the Scurvy at Sea,* published in 1768. He specifieally recommended boiled wort or infusion of malt as a preventive and eure. Cook had been directed to try MacBride's system during the voyage, and William Perry, Cook's surgeon's mate and later ship's surgeon, reported on it favorably.

A letter from no less a personage than Linnaeus to a fricnd in 1771 sums up Cook's achievement in the nutritional and medical aspects of conquering seurvy as follows, "It is, I think, of much more than passing interest to note that, on the long voyage of the Endeavour scurvy was controlled by the intelligent use of antiseorbutics then known. Among thc 95 men on the Endeavour after an absence of nearly three years, there werc no deaths from scurvy. This was the terrible seourge that often affected the crews of all sailing ships bound on long voyages. Aided by Banks and Solander, two good botanists, Captain Cook and his staff were able to utilize the vegetable resourees of the various islands visited in a more effective way than any previous expedition."

Cook himself somewhat understated his case in this quote from his narrative, "I believe, there was hardly a man in the ship who did not attribute our being so free of the scurvy to the beer and vegetablcs we made use of at New Zealand; after this, I seldom found it necessary to order any of my people to gather vegetables whenever we came where any were to be got, and if scarce, happy was he who eould lay hold of them first."

It is of interest now to turn to descriptions of the speeific utilization of plants that Cook came across as he ventured into the Pacific. Joseph Bank's journal describes their experience in Terra del Fuego as follows, "Among other things the bay offers there is plenty of winters bark, easy to be known by its broad leaf like a laurel of a light green colour and blueish underneath. The bark is easily stripd off with a bone or stick as ours are barkd in England."[6] The bark he spoke of was Drimys winteri, which was named for Captain John Winter. He was with Drake in the Straits of Magellan in 1578 and there he successfully used it to combat seurvy. The bark was much valued as an antiscorbutic and was extensivcly used for this purpose in Europe for over two eenturies.

Banks noted in Terra del Fuego that there was an abundance of wild celery, Apium antiscorbuticum, and "seurvy grass," Cardamine glacialis. Scurvy grass was a term applied loosely to many unrelated plants which had antiscorbutic properties. These plants were callcd "verdura" by the Spanish navigators and were utilized by them in the Pacific. This group ineluded the plants Cardamine nasturtoides, C. glaeialis, Brassiea juncea, Portulaca oleracea and Sesuvium portulacastrum. Banks also described the celery and the grass as being as pleasant to the taste as any of the leeks found in Europe. He also believed them to possess as much virtue in curing scurvy.

Banks deseribed how scurvy grass was found plentifully in damp places near springs and in general cverywhere near the bcach. He noted that, "The grass, when young, lay flat on the ground and has many bright leaves standing in pairs opposite to each other with an odd one at the end generally making up the fifth leaf on the footstalk. The grass shoots up in stalks as high as two feet at the top of which are noted small white blossoms which are sueceeded by long podds."

The wild eelery was describcd as resembling very much thc cclery in the gardens in England exeept that, "the leaves are of a deeper green and the white flowers stand in small tufts at the tops of the branches. The celery grows plentifully near the beaeh, generally in the first soil whieh is above the spring tides, and is not easily mistaken, since the taste resembles eelery or parsley or something in between."

On Raiatea, Banks described a low point of land which was covered with Pandanus tectorius, along with several plants he had not seen at Tahiti. Among these plants was Lepidium bidentatum, which he was told was the plant called seurvy grass by the voyagers. This grew plentifully upon all the low islands.

In New Zealand, Banks wrote that the crew

found great benefit in their health by eating plentifully of wild celery, Apium prostratium and A. filifolium, and of a kind of cress which grew abundantly by the sea side. This cress probably referred to the plant Cook himself called scurvy grass, Lepidium oleraceum. While in New Zealand, Cook instructed his men to go ashore and brew a decoction from the leaves of a tree that resembled the American black spruce. There were no vegetables there so he made a decoction of these leaves which was then mixed with the juice of wort and used to ward off scurvy. This use of spruce leaves parallels Cartier's experience in Canada over two centuries before.

Another antiscorbutic Cook took on his voyage and placed great faith in was sauerkraut: cabbage, salted and fermented with juniper berries and aniseed. It was stored in casks, and a pound was served to each man twice a week and sometimes even more often when at sea. Another product brought on his voyages was inspissated carrot juice, but this gave disappointing results when pitted against scurvy.

While he was in the Pacific, Cook described the use of wort, marmalade of carrots, and "rob" of lemons and oranges to reverse the symptoms of scurvy. Wort was prepared by evaporating the juice of malt as beer or wort to a thick syrup. This was stored in casks and was then added to water as required in the proportion of one to ten, twelve or sixteen parts to make a palatable drink. Cook had such confidence in this preparation that he declared it was without a doubt one of the best antiscorbutics yet discovered. The "rob" of lemons and oranges was prepared by boiling the juice of the ripe fruits to the consistency of syrup.

Cook prepared a paper outlining the ideas he had used to combat scurvy on his first and second voyages, and it was read before the members of the Royal Society in London.[7] This was accorded general acclaim and as a real achievement in that era. He had already been elected a Fellow of the Society; now he was voted the Copley Gold Medal. This, Britain's highest honor for intellectual achievement, was awarded for his contribution to the health of seamen. This medal has never been awarded to anyone else for an achievement in nutrition.

The world knows Cook as the leader of the three largest and greatest discovery voyages ever made. He put Australia, New Zealand, the Hawaiian Islands, New Caledonia, South Georgia, the South Shetlands and numerous other islands, atolls and island groups on the maps of the North and South Pacific and the South Atlantic. He was the first man to cross the Antarctic Circle and he charted Alaskan waters and sailed the Bering Straits. He did all these things by being the master of his diet as well as master of his ship, as no one else had ever done before him and as few have done since.

REFERENCES

1. Hess AF: *Scurvy, Past and Present.* J. B. Lippincott Co., Philadelphia, 1920.
2. Allison RS: *Sea Diseases.* John Bale Medical Publications, Ltd., London, 1943.
3. Merrill ED: The botany of Cook's voyages. Chronica Botanica 14:230, 1954.
4. Hale JR: *Age of Exploration.* Time, Inc., New York, 1967.
5. Thomas L: From Eve to astronauts. *Nutrition Today* 4:6-7, 1969.
6. Banks J: *The Endeavour Journal of Joseph Banks,* 1768-1771. Angus & Robertson, Ltd., Sydney, 1963.
7. Villiers A: That extraordinary sea genius, Captain James Cook, *Nutrition Today* 4:9, 1969.

Whenever a system becomes completely defined, some damn fool discovers something which either abolishes the system or expands it beyond recognition. (Finagle's Fifth Law).

WELLAND A. HAUSE, M.D.

Group A Beta Hemolytic Streptococcal Bacteremia

Review and Report of 14 Cases

A senior medical student from the University of Hawaii's first class has something to say about streptococcal septicemia.

STEPHEN M. KREITZER, B.A., *New York City*

Group A beta hemolytic streptococcus caused about one-fifth of bacteremias 40 or more years ago. Today it causes less than one-twentieth, though the mortality is still high. Early treatment is urgent.

BACTEREMIA caused by the Group A beta hemolytic streptococci is a rarity.[1] Prior to 1930, before the Lancefield streptococcal group classification, bacteremias due to beta hemolytic streptococci accounted for about one-fifth of bacteremias and three-quarters of the puerperal septicemias.[2] The mortality rate for such bacteremias was over 70%.[3] Today the Group A beta hemolytic streptococcus accounts for 4 to 5% of all pathologically significant bacteremias,[4,5,9] and its mortality is reported from 26 to 72%.[5,6] As will be discussed, beta hemolytic streptococcemia seems to occur primarily in patients with some other debilitating systemic disease.

CASE 1.—A 46-year-old divorced secretary with a 20-year history of alcoholism (1-1½ fifths per week) fell on a concrete step two weeks prior to admission and "tore some skin" over her left shin. Over the next two weeks the leg became swollen, red, hot, tender, and increasingly difficult to walk on. The wound itself had been covered by bandages and remained unobserved. On the day of admission the patient's sister telephoned her and noted that she seemed "drunk." The sister came to take her to the hospital. On the way the patient suddenly became increasingly agitated, cyanotic, tachypneic, and diaphoretic for a 2½- to 3-minute period and then returned to her previous state. A second identical episode in the hospital was treated with 100% oxygen, lasted five minutes, and spontaneously cleared. The patient was admitted to rule out a pulmonary embolus.

Eight months prior to admission the patient had pneumococcal pneumonia treated with penicillin. She had smoked one pack of cigarettes per day for the past twelve years.

On admission temperature was 104°F., pulse 120 and regular, respiratory rate 30 per minute, and blood pressure 140/90. The lungs were clear, heart was normal. The abdomen was soft and nontender, with a palpable, hard, smooth, nontender liver felt 3 centimeters below the right costal margin. There was a 3 x 2cm left inguinal lymph node. Pulses were strong and equal bilaterally including the dorsalis pedis and posterior tibialis. On the left shin was a 10 x 5cm open, purulent, malodorous wound, 4.5cm deep. The entire left leg was hot, red, and edematous. There was no crepitation.

Chest x-ray and lung scan were normal. Urine contained myoglobin but no albumin, acetone, glucose, cells, or bacteria. The white blood cell count was 17,000 with 86 polymorphonuclear cells, 11 band forms, and 3 lymphocytes.

Two days later the white blood cell count was 34,000 with 87 polys, 9 band forms and 3 lymphocytes. The blood urea nitrogen was 20 mg%, glucose was 90 mg%, sodium was 138 mEq, potassium was 2.8 mEq, chlorides were 88 mEq and serum CO_2 was 21 mEq. Enzyme studies revealed a serum glutamic oxalacetic transaminase of 460, a serum glutamic pyruvate transaminase of 80, a serum lactic acid dehydrogenase of 950 and a creatinine phosphokinase of 450.

The patient was treated for sepsis with 2gms/day oxacillin and 1gm day kanamycin, for embolization phenomena with heparin, for hypokalemia with potassium chloride, and for prophylaxis of complications of myoglobinuria with mannitol. Cultures of the wound on the left lower extremity grew staphylococcus aureus, coagulase positive, and Group A beta hemolytic

Since submitting this article, the author has received his M.D. degree and is currently serving a medical internship at the Bronx Municipal Hospital Center.

Received for publication October 18, 1970.

streptococcus. Blood cultures grew Group A beta hemolytic streptococcus. Kanamycin was stopped and the patient was treated with 2gm oxacillin and 1.2 million units penicillin per day. The patient became afebrile on the fifth hospital day but was then noted to show gangrenous changes on the tips of four toes on her right foot. Her pulses remained normal. The necrotic changes advanced within three days to incorporate the entire four toes and the tip of the fifth. Surgical consultants believed the patient was experiencing arterial spasm. A bilateral sympathectomy was performed. The post-operative course was uneventful and the patient was transferred to the Plastic Surgery service for skin grafting to the left leg.

CASE 2.—An 81-year-old retired photocopier was sent to the emergency room from a local nursing home with a three-day history of being obtunded, oliguric, and febrile to 102.6°F. His history includes four years of Parkinsonism and three years of progressing mental deterioration. There was no history of heart disease, renal disease, hypertension or diabetes.

The patient was a cachectic, elderly man who did not respond to any auditory or painful stimuli. The blood pressure was 70/50, the pulse was 80 and regular, respirations were 22 per minute and temperature was 99.4°F. The skin examination revealed a deep 8 x 6cm decubitus of the sacrum and small areas of necrosis on both shoulders, heels, and ankles. All of these decubiti were characterized by a fruity odor. The patient exhibited total flexor rigidity, making it impossible to adequately test extensor motor strength. There was no response to pin or ice. All deep tendon reflexes were active, with no Babinski sign. The chest had an increased anterior-posterior diameter, with breath sounds greater on the right than on the left. The heart sounds were distant but there were no murmurs, S_3, or S_4. Pulses were weak in all four extremities. The abdomen was unremarkable.

Chest x-ray showed no acute infiltrates. EKG showed right bundle branch block. Urine showed two plus protein, no sugar or acetone, and 20 white blood cells per HPF, with sheets of Gram-negative rods. The white blood cell count was 13,000 with 65 polys, 3 stabs, 24 lymphocytes and 8 mononuclears. The blood urea nitrogen was 30mg% and the serum electrolytes were consistent with a 10% dehydration state. Cerebrospinal fluid was normal.

The patient was initially treated with hydration, kanamycin and oxacillin. Four blood cultures grew Group A beta hemolytic streptococci. The kanamycin was stopped and the patient was treated with 2gms/day oxacillin and 2.4 million units penicillin. The patient never was febrile in the hospital. He expired 40 hours after admission. No post mortem examination was performed.

These two cases represent the thirteenth and fourteenth cases of Group A beta hemolytic streptococcal bacteremia recorded at this hospital since 1966. These cases, as well as the earlier 12, are summarized in Table 1.

TABLE 1.—*Jacobi Hospital patients with group A beta hemolytic streptococcal bacteremia diagnosed by repeat blood cultures.*

AGE	SEX	PRESENTATION	SIGNIFICANT HISTORY
7	F	Trauma to right arm; cellulitis, febrile	Hb S/A, metaphyseal dysostosis
8	F	Varicella	Radiculomyelitis
47	M	2° and 3° burn on legs 21% of body	None
29	M	Upper respiratory infection, head trauma, bacterial meningitis	Previously worked up for a suspected communication between CSF and sub-galeal space. Son died of leukemia
53	F	Febrile	Endometrial adenocarcinoma with multiple bony metastasis
66	M	Left inguinal hernia	Milroy's disease
61	M	Pneumonia	Congestive heart failure pulmonary edema and pulmonary infarcts—old ASHD
55	F	Febrile	Pyelonephritis
66	F	Bilateral breast abscesses	Atrial fibrillation, congestive heart failure, cholecystitis, stress ulcers
61	M	Pneumonia	Bronchogenic carcinoma
44	M	Trauma to right leg	Alcoholism, Laennec's cirrhosis
53	M	Pneumonia	Metastatic anaplastic, giant cell carcinoma primary site? chronic alcoholism
46	F	Trauma to left leg R/o pulmonary embolus, febrile	Chronic alcoholism
81	M	Lethargic, oliguric febrile	Parkinsonism old ASHD

A number of interesting observations regarding these patients deserve elucidation. In Case 1, gangrene occurred in the foot contralateral to her septic focus. Acral foci of gangrene are common in gonococcemia, but rare in Gram positive sepsis.

Dalldorf *et al*[7] reported such distal gangrenous changes in a 22-month-old infant who died of Gram positive sepsis. They feel that the cytolytic exotoxins such as streptolysin, streptokinase (plasmin), streptodornase, and the hemolysins not only lyse the erythrocytes but severely damage the endothelium of blood vessels. This vascular damage may be one reason for the decreased blood perfusion to a distal organ, apart from actual emboli on the arterial side of the circulation. This would explain the observation that Gram positive sepsis is usually not associated with a fall in plasma fibrinogen levels. In managing such a patient, heparin would not be the drug of choice, since this primarily is a vascular disease and not a coagulopathy.

Collins and Nadel[8] reported a case of a 64-year-old man with rapidly spreading bullous wet gangrene due to a Group A beta hemolytic streptococcus, in which at autopsy small-vessel vasulitis was seen throughout the otherwise unaffected subcutaneous tissue. Throughout these studies it is evident that the bacterial toxins and enzymes themselves produce the effects of the bacteremia. This is in contradistinction to any effects of the inherent virulence of the M protein within the streptococcus itself. M protein seems to interfere with the phagocytosis of the streptococci.[9]

In the 14 cases presented, the focus of infection is readily determined in nine instances. In five cases trauma sites are the focus, in three cases the lungs are the focus and in one case, breast abscesses. In five instances the patients presented with fever and appeared septic clinically. Collins and Nadel[8] state that in their patients intravenous sites and wounds were the foci of streptococcal penetrance into the body. McCabe and Abrams[2] reported that in their cases of puerperal sepsis, beta hemolytic streptococci could be cultured from the pharynx in about 50% of all cases and from the feces in 20%. Henkel *et al*[6] were able to find the focus of bacterial entrance in 36 out of 49 cases, with surgical wounds, pneumonitis, and urinary tract infections as the common sites. Transient bacteremias may occur while brushing teeth or during dental manipulations, and depending on the patient's immunological response, streptococci may lodge in some site such as the meninges or joints. These sites may then serve as the foci for true bacteremias at a later date.[10]

In this series it actually is the immunological response, along with underlying systemic disease, that seems to play the predominant role in determining which patients have a streptococcemia. Of these fourteen, three have solid tumors, three have cardiovascular disease, two have chronic alcoholism (one with cirrhosis by biopsy), one has Milroy's lymphedema, one with chronic acute pyelonephritis, one with varicella at the time of sepsis, one with a hemoglobinopathy. Of the two in the series with no underlying disease, one has a family history of leukemia. In Michaels' series of hemolytic streptococcal bacteremias[11] all his patients had received between 100 mg and 1300 mg hydrocortisone per day for at least one and up to ten days before the clinical manifestations of sepsis. In this instance, medication presumably lowered host resistance.

Johnson and Sell[5] reviewed 198 cases of septicemia in children; nine were true Group A hemolytic streptococcal in nature. Of these nine, six had either leukemia or sickle cell disease. Henkel *et al*[6] described 49 cases of Group A beta hemolytic strep bacteremia at Memorial Hospital with no age or sex preponderance. Thirty-one in his series had solid tumors, nine had lymphoma and six had leukemia.[6] Duma and the Boston group[9] state that 74% of their patients with streptococcemia have either a malignancy or a chronic debilitating disease of the kidney, liver, or central nervous system. Dudding's group[12] reported 13 cases in children with leukemia. In the Duma study of 91 streptococcal septicemias only 19 were caused by Group A organisms, with 26% mortality. Twenty-seven bacteremias were caused by the enterococcus, with a 42% mortality, and seven were caused by the Group B organism, with a 43% mortality. In this series, also with no age or sex predominance, there were five deaths due to sepsis, or a 36% mortality.

As with any pathologic process, early clinical recognition, plus appropriate cultures and determination of antibiotic sensitivities, is of utmost importance in managing a streptococcal septic patient. However, since this form of sepsis often accompanies some other systemic disorder such as neoplasm, and since the underlying disorder may either mimic or mask sepsis, early clinical recognition of this form of bacteremia is difficult. Prognosis is often dependent on how intact the patient's immunologic response is, which in turn often is dependent on underlying disease or on systemic medications such as steroids or antimetabolites. Rosenow and Brown[13] felt that a good prognosis was proportional to the patient's white blood cell count. In the cases summarized here and in those of Henkel *et al*,[6] neither lowered white blood cell count, lowered gamma globulin levels, nor hypotension represent reliable factors in predicting the outcome of streptococcemia.

REFERENCES

1. Stollerman GE: Clinical syndromes of Group A streptococcal infections, in Beeson and McDermott: *Textbook of Medicine*. Philadelphia, W. B. Saunders Company, 1967, page 167.
2. McCabe W, Abrams A: An outbreak of streptococcal puerperal sepsis. *New England J Med* 272:615-618, 1965.
3. Goran A, MacCallum M, Anderson D: Puerperal streptococcal septicemia. *Lancet* 2:913-915, 1962.
4. Altmeier W, Todd J, Inge W: New aspects of septicemia in surgical patients. *Arch Surgery* 92, 1962.
5. Johnson R, Sell S: Septicemia in infants and children. *Pediatrics* 34:473, 1964.
6. Henkel J, Armstrong D, Blevias A et al: Group A beta hemolytic streptococcal bacteremia in a cancer hospital. *JAMA* 211:983, 1970.
7. Dalldorf F, Carney C, Raney R et al: Pulmonary capillary thrombosis in septicemia in an ischipagus tetrapus conjoined twin. *JAMA* 206:583, 1968.
8. Collins R, Nadel M: Gangrene due to hemolytic streptococcus, *New England J Med* 272:578, 1965.
9. Duma R, Weinberg A, Medrek T et al: Streptococcal infections: a bacteriologic and clinical study of streptococcal bacteremias. *Medicine* 48:2:87, 1969.
10. Dubos R, Hirsch J: *Bacteriological and Mycotic Infections of Man*. Philadelphia, Lippincott, 1965, page 379.
11. Michaels L, Buttoo A, Hills P: Fulminant hemolytic streptococcal infections. *Canadian J Surg* 12:318, 1969.
12. Dudding B, Humphrey B, Nesbit M: Beta hemolytic streptococcal septicemias in childhood leukemia. *Pediatrics* 43:359, 1969.
13. *Rosenow* E Jr, Brown A: Septicemia: review of cases,1934-1936. *Proc Mayo Clinic* 13:89, 1938.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

The Pacific Southwest Regional Medical Library Service

NELSON J. GILMAN,* *Los Angeles*

THE Pacific Southwest Regional Medical Library Service (PSRMLS) is part of the nationwide Biomedical Communications Network sponsored by the National Library of Medicine (NLM) and functions as an intermediate link between NLM and local health science libraries in Arizona, California, Hawaii and Nevada. Centered at the UCLA Biomedical Library, PSRMLS is one of eleven regional medical library services.

PSRMLS offers a variety of services as described below.

INTERLIBRARY LOAN

Books and journal articles may be requested from PSRMLS through a health science library.

Individuals who do not have reasonable access to a health science library may request assistance from other libraries. If this is not feasible, they may request items directly from PSRMLS.

Interlibrary loan service includes provision of photocopies of journal articles in lieu of the physical volumes.

Photocopies of articles are retained by the individual and are not returned to PSRMLS. For example, a surgeon in Hilo needs a specific article on congenital heart defects and finds that it is not available in his hospital library or in the larger medical libraries in the Islands. His librarian forwards the request to PSRMLS by mail, teletype or telegram. In emergencies, a request could be made by telephone. The article is photocopied and sent by return mail to the surgeon's office. If for some reason the request could not be filled, PSRMLS would notify the surgeon's librarian and forward his request by teletypewriter to the National Library of Medicine.

MEDLARS

Medical Literature Analysis and Retrieval System (MEDLARS) is a computer-based system designed to achieve rapid bibliographic access to the world's biomedical journal information. One of the functions of MEDLARS is to provide bibliographies in response to the information needs of individual requesters. These bibliographies are produced on biomedical subjects for which printed indexes are not adequate sources. The decentralized search station at UCLA is part of PSRMLS. Search requests are accepted by interview, by submission of a standard request form, or by telephone. They may be submitted through a library or by individual health professionals.

REFERENCES AND BIBLIOGRAPHIC SERVICES

Reference service is offered to individuals directly or through libraries by mail, TWX, telephone or on a walk-in basis. It includes the following categories: (1) answers to factual questions where no interpretation of information is required, (2) short bibliographic searches on subjects not suitable for computer-based information systems, (3) bibliographies and information from MEDLARS and other specialized information centers, (4) identification of citations, (5) location of translations of foreign language material, (6) identification and referral service on medical films and videotapes, and (7) preparation of bibliographies and reading lists for use in continuing health professional education programs.

CONSULTING

At the request of a hospital administrator or librarian PSRMLS will provide a consultant to advise in person or by mail on the planning, organizing, staffing or maintaining of a health sci-

* Associate Director, Pacific Southwest Regional Medical Library Service, UCLA Biomedical Library.
Received for publication December 8, 1970.

ences library. Sources of extramural support, preparation of grant requests, equipment and physical quarters, and recruiting sources are other areas in which the consultant may provide information.

CONTINUING EDUCATION

PSRMLS offers continuing education programs for both health science professionals and librarians. For the professional the services of the PSRMLS speakers bureau are available. A variety of one to two-hour continuing medical education programs could be presented by the PSRMLS staff. Topics include MEDLARS, current alerting services, basic abstracts and indexes, hospital library/information services, and PSRMLS services.

One-day institutes directed toward personnel in charge of hospital libraries are given throughout the Pacific Southwest. Topics covered include book selection, references services and the use of *Index Medicus*. Brief orientation sessions on PSRMLS services are also given to health science librarians.

Further information about PSRMLS services is available from the office of the Associate Director, PSRMLS, Biomedical Library, The Center for the Health Sciences, University of California, Los Angeles, California 90024.



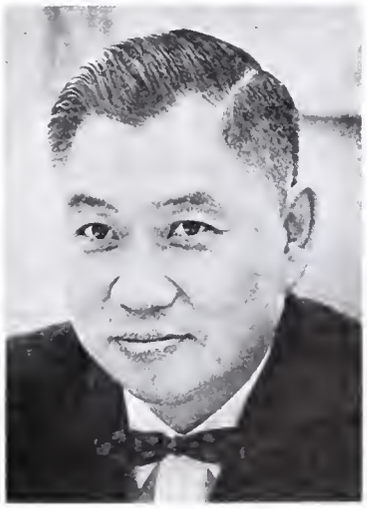
of the
tetracycline-nystatin
products

...none is lower priced

TETRACYCLINE HCl 25 mg. NYSTATIN 25,000 U./cc.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

374-1



The President's Page

The HMA has been, and always will be, interested in the quality of medical care in our State.

Historically, the HMA in 1965 appointed a committee to study the health needs of our State. Shortly after this, the Bureau of Research and Planning was formed. It recommended that the HMA take the lead in evaluating medical care in our community.

In February 1967, a grant application was submitted to the Honolulu Chamber of Commerce and the sum of $7,200 was received. In addition, $100 was received from the Watumull Foundation. Dr. Paul J. Sanazaro, then Director of the Division of Education of the Association of American Medical Colleges, was selected to study the feasibility of a comprehensive survey of the quality of medical care in our State.

His report, "Preliminary Survey of Medical Care in Hawaii," appeared in the July-August 1968 issue of the HAWAII MEDICAL JOURNAL. It said, in part, "It should be made clear that, as of this date, no community in the U. S. has as yet collected the definitive information required for an evaluative judgment regarding the quality of medical care it provides and *receives.*"

It was the intention of the HMA that Dr. Sanazaro followup with the comprehensive survey. Being unable to do so, he recommended Dr. Beverly Payne of the University of Michigan, who met with the HMA Council in September 1969.

In December 1969, a grant application was submitted to the National Center for Health Services Research and Development and in February 1970, Dr. Payne began the Study on the Quality of Personal Medical Care in the State of Hawaii. This study, sponsored by the HMA, is the first statewide appraisal of medical care in the nation.

The first two phases of the study, (1) Episode of Illness study (a comprehensive review of the quality of care in 22 acute general hospitals throughout our State) and (2) office or ambulatory care, have been completed.

Feedback seminars have been undertaken by Dr. Beverly C. Payne and his staff and are being continued by Dr. Alexander S. Anderson of RMP Hawaii, to our four largest participating hospitals. Criteria sheets for diagnostic and therapeutic care for 21 medical conditions for better quality care have been set up in the four hospitals, namely, Queen's Medical Center, St. Francis Hospital, Kuakini Hospital, and Kaiser Hospital. St. Francis Hospital is using criteria sheets for 18 of these medical conditions—the other three do not apply. Kuakini Hospital is using 8, as requested. Kaiser Hospital is also using 8, with slight modification. Queen's Hospital Medical Advisory Board has accepted the concept and this is being reviewed at departmental levels before implementation.

In late 1971, I hope, there will be a followup study of the results of these criteria, implemented by feedback seminars.

The initial results of the feedback seminars were best described by Dr. Anderson. First there was resistance, then anger, then curiosity, and finally identification of problems and a desire to do something about them. Not all the data collected were useful, especially the history and physicals section.

The staffing for this project, the Hawaii Experimental Medical Care Review Organization, will principally be the core staff of RMP Hawaii, with hired personnel as needed.

It is too early to determine whether the data to date are useful to the practicing physicians. I feel they will be.

The HMA plans to continue to influence the practice of medicine by its ongoing programs in the study of medical care, in medical education and in medical research.

* * *

The above was our introductory statement for a grant application of $382,268 for the Hawaii Experimental Medical Care Review Organization (HEMCRO), to be sponsored by the Hawaii Medical Association with Dr. Alexander C. Anderson as the principal investigator. The meeting was held on June 8, 1971, at the San Franciscan Hotel in San Francisco with the following panel representing the survey team for the National Center for Health Services Research and Development; Sam A. Edwards, Ph.D., Chairman; Thomas H. Ainsworth, Jr., M.D., Gerald E. Besson, M.D., James Haviland, M.D., John Williamson, M.D., Robert Long, M.D., James Tenney, M.D., Dwight L. Wilbur, M.D.

Eight foundations for medical care presented applications. Hawaii's application was the only one presented by a state medical association. The objectives for the HEMCRO are as follows:

1. To provide consultation and technical staff assistance for continuous hospital-based medical care review.
2. To develop the procedural and technical methodology for effective review of the quality of ambulatory care in a variety of settings.
3. To provide a continuing system of interval feedback on quality of ambulatory and hospital-based patient care.

Hawaii was ably represented by Drs. Beverly Payne and Robert Worth. We owe each a great big "thank you." Dr. Payne's unsolicited, spontaneous, final summation was superb. Our thanks also to Dr. Alexander S. Anderson who prepared the grant application, to those who met so many times to finalize the application, and to those who added their endorsement on such short notice.

This brings us up-to-date to the present status of the study of quality care in our State started by our Medical Association. We have now been funded for this project.



Editorials

Effecting "Death With Dignity"

Homicide is forbidden by law, which calls it manslaughter, or murder, and punishes persons found guilty of it.

The law takes little account of motivation, beyond the general attitude that self-defense is an excuse for killing an attacker. It is *no* defense, however, to argue that your motive was compassion for your victim, or that he would have died in a short time from other causes.

Neither is it a defense to show that the victim asked you to end his life—or even merely to make it possible for *him* to end it. Helping a would-be suicide to achieve his own death has been ruled manslaughter by a Michigan court.

Homicide by inaction—by stopping something that is being done, or by not doing something—is in a gray area. Such actions, or inactions, usually qualify as "mercy killing." One legal authority has said that he could find no instance of indictment for mercy killing by omission.

The principle of *not* deliberately prolonging the process of dying for a hopelessly ill or deteriorated patient is subscribed by most physicians—at least in its more obvious applications. No physician would suggest coronary bypass surgery for a man dying of some incurable disease, or comatose with irreversible brain damage; most would not even order antibiotics for pneumonia in a patient with terminal cancer.

What is needed, however, is legal protection for the physician who wishes to respect his patient's express desire not to have his life maintained after it has become permanently insupportable or meaningless by reason of hopeless illness or deterioration. Since the question may arise after he has become incapable of expressing this wish, past president John J. Lowrey suggests, in his essay in this issue of the JOURNAL, that he should communicate it in writing to the members of his family, from whom the physician can then receive guidance.

Legal protection for the physician against a charge of manslaughter through inaction—failure to order transfusions, nasal feedings, antibiotics, major lifesaving surgery, or the like—is needed, and could be provided by our legislature. Such a law would have no effect on anyone who did not wish to write out such instructions; it would merely help those who did.

Sir George Pickering, a distinguished elder statesman of English medicine, suggests that old people (he is 66) who are unable to look after themselves should not be given antibiotics. Nature, he suggests, should be allowed to take its course, lest—with increasingly successful transplant surgery—we overcrowd the world with old persons "stuffed with other people's viscera but with their own senile brains." We should also regard death with less aversion. He hopes, he said, that if people assemble after he dies they will be given champagne.

HAWAII MEDICAL JOURNAL

Sickness Care vs. Health Care

"The present system of delivering health care concentrates over 90 percent of its effort on curing the sick and less than 10 percent on prevention. Recently the Health Insurance Institute found from a study conducted by the Massachusetts General Hospital that about three out of five hospitalizations could have been avoided by preventive measures."

Some variation on this theme is often heard when changes are proposed in our health care system. As President Nixon put it in his recent health message: "If more of our resources were invested in preventing sickness and accidents. fewer would be spent on costly cures . . . In short we should build a true 'health' system—and not a 'sickness' system alone."

Among "health-oriented" organizations often prominently cited by government health planners and others is the Kaiser-Permanente medical care program. They maintain that Kaiser's substantially below-the-norm hospital utlization rates are evidence of systematic preventive care.

How much of this argument is reason and how much is rhetoric?

The Kaiser people themselves make no claims to great advances in the delivery of preventive medicine. They point to their research project specifieally set up to determine whether patients who receive an annual physical examination are healthier than those who do not. For five years they have given annual physicals to a group of 5,000 persons. At this point in the study they are unable to detect any significant differences between the health of the examined population and that of the unexamined control group. While they think that some differences may emerge in the second five years, they are frank to admit that they are not sure, and add that the therapeutic value of the yearly physical is at present an unknown quantity.

Further, they indicate that their physicians, like all other physicians, have been trained primarily in the treatment of episodic periods of illness, and that this, by and large, is the type of medicine they practice.

Seen in this light, Kaiser's low hospitalization rates are not the result of preventive medicine, but are produced by a number of other factors, among them the performance on an outpatient basis of a variety of procedures that elsewhere are usually done in the hospital.

Considerable effort is being spent on selling the American people the idea that new forms of medical care organization will make them healthier. The campaign may succeed. But if revisions in our health care system are bought on the basis of such unproved claims, the result is likely to be disillusionment — both with the sponsors of the changes and the changes themselves.

Reprinted from Physician's Management, Vol. II, No. 4, April, 1971.

Hawaii Academy of General Practice

At a recent small gathering of members of a committee of the Hawaii Medical Association, meeting with a popular Representative to the Congress of the United States, it soon became apparent that the Congressman had many other priority interests besides things medical. The "medical picture" was not in focus for him at that time, but would come into focus later.

This may well be typical of an attitude among citizens in general in our country. They have a vague, fuzzy impression of some sort of national health legislation looming in the periphery. There is no better way to keep people ignorant of the subject at hand than by using acronyms as euphemisms.

"HMO" is one of these new ones. In time, HMO will be as glibly rattled off the tongues of proponents and opponents in the Congress as well as among the general population as GOP or OEO, but for the present the acronym is not even familiar to the health professionals. To explain that it stands for "Health Maintenance Organization" does not readily bring understanding. The fact is that the new term actually cloaks an old concept, which is the closed-panel system of medical care with a captive patient-pool and fixed costs via a capitation fee to cover in- and out-patient comprehensive medical service. "Cost control" is the lid for this pot!

Such closed-panel systems of medical care have been around for many years. Is it not a significant commentary on their popularity with consumers, even with, and inspite of proponential pressure on the part of labor unions, that only some three to five percent of the people have elected to enroll in such schemes? Granted, there has also been resistance from the professional providers; the many reasons behind this cannot be lightly dismissed.

The come-lately enthusiasm by the government for this particular approach to solving the problem, in the face of small previous interest in such an approach, must be viewed critically. The critical analysis must also take into account the fact that "the problem" is not an over-all one but pertains only to certain groups of people, and that the government's proposed solution would scrap all that has been proven to be good in the past.

The cloak with which this old concept is newly presented is pictured in glowing terms and colorful design conceived to disguise the basic frame beneath. Despite these terms: "Emphasizing prevention and early care," "providing incentives for increasing productivity of resources," "offering opportunities for improving the quality of care," etc., the crux of the governmental interest is in *cost-control*. Take away these coverings, all of which are of weak cloth, and the framework beneath is revealed as not being acceptable. Pious allegations as to "maintaining high quality" not withstanding, when the lid of cost-control is clamped down, quality of medical care inevitably *will* decline!

HMO's are basically NOT in the consumers' interest—his wishes and his concern for self or for his family will be checked by cost-control.

HMO's are not in the physicians' interest—his professional best judgment, his range in both diagnosis and treatment will be curtailed by cost-control.

HMO's are not in the best interest of hospitals and health facilities; these are providers of services rather than goods. The lid of cost-control will clamp down hardest on salaries and wages, thus curtailing services.

When, as now, the government must face up to the responsibility of managing national medical care, it can hardly do so without instituting cost-control!

Beware the HMO!

J. I. FREDERICK REPPUN, M.D.

Inside HMA

HAWAII MEDICAL JOURNAL

Telling It Like It Is

I won't be boring you with committee reports this month. The committees have not been meeting—or if any have, they haven't bothered to report.

The Council has been busy. In response to obvious need, and to prodding from several quarters, including me, the Council requested and received authority from the last House of Delegates to begin streamlining HMA's committee structure. Action will follow a survey by an Administrative Review Team from the AMA, scheduled to arrive here August 8.

HMA has a grant from the National Center for Health Services Research and Development (HSHA) in the amount of $180,000 for the formation of an Experimental Medical Care Review Organization (EMCRO), as an extension of Dr. Payne's work on the quality of medical care. Dr. Alexander Anderson is project director.

The Workmen's Comp fee schedule promised us last year is complete but has been delayed in transit through the Governor's office. Because of this, the Council has taken legal action to force its publication. If it truly adheres to the principles expressed by the state last December, we will probably be able to live with it. If not, we may have to go to court again to force the state to live up to its own law. Why should the physicians of Hawaii continue to subsidize industrial accident cases? Shouldn't they be handled like any other patient?

Interesting that the state's own tapes of the hearings of last December proved to be so bad that they had to borrow HMA's tapes to make their official record of their actions.

Now that the news is out of the way, I want to flail away at a few archaic practices and sacred cows. In the first place, I see no need for an annual "interregnum" on the activities of HMA for the first two or three months each year. Each president has served a full year as president-elect. He can, and should, make committee assignments, and appoint chairmen, at the annual meeting, if not sooner. He should meet with the chairmen sometime during the annual meeting, and give them a charge as to what he wants accomplished during the coming year, and insist that they get started promptly. If this practice can't be started informally, let's change the Bylaws to require it. It is ridiculous for each committee to waste a quarter of every year waiting to be fully organized before beginning work. If any committee is not more important than that, and doesn't have pending work, then let's do away with the committee, by merger or euthanasia.

Needed is a better understanding by the committees of where they are going. I invite each committee member to ask himself the following questions, and write me the answers:

(1) What is the real purpose and function of my committee?
(2) What is the committee's goal?
(3) What progress has been made toward this goal in the past year?
(4) What should we aim to achieve in the coming year?

I also invite every member of HMA to ask himself the following questions:

(1) What are the purposes of HMA?
(2) What are its immediate goals?
(3) Why do I belong to HMA?
(4) What do I owe HMA?

Can you answer these questions? If so, please write the answers to me or to Herb Chinn—if you are not working in HMA, you should be. If, like most of us, you are vague about the answers, don't you think it is time for a serious dialogue on the goals of HMA? Generally, each president has and expresses certain short range goals, and usually reaches them, and this is fine. Shouldn't HMA, your organization, have clearly defined long range goals? Wouldn't it help to have them clearly set forth, for all our members, and the whole world, to see?

continued page 335

Slants and Angles

HAWAII MEDICAL JOURNAL

Man's Best Friend

Most Hawaiian households boast some type of pet ranging from the lowly poi dog to exotic tropical fish. Pet shops enjoy a booming business even importing rare animals from distant lands to satisfy the jaded appetites of their more neurotic customers.

Now a new household pet is capturing the hearts and minds of our animal lovers—the tapeworm. Consider the advantages of keeping one of these interesting and unusual creatures. No special feeding problem. He is very happy just eating what you eat. During vacations you don't need a pet sitter. He goes along with you everywhere, undoubtedly enjoying the change of scene and a chance to try new and unusual foods. He is very quiet and rarely seen, though always there, a constant and faithful companion. What more could anyone need?

Pins and Needles

A report in the *Honolulu Star-Bulletin* (July 10, 1971) mentions that the Cambodian Prime Minister, Lon Nol, who recently returned to Phnom Penh after treatment at Tripler for a massive stroke, is now receiving acupuncture therapy from a Chinese physician. The persistence and continuing wide usage of acupuncture, even in countries where Western medicine is available, suggests that this ancient form of treatment must, indeed, relieve symptoms and, possibly, effect cures in certain selected disorders.

Treatment is usually carried out by piercing the skin at specific points with needles made of silver, gold or steel. There are 365 acupuncture points on the body surface and their stimulation by needling is thought to affect to flow of certain vital substances in the body, thereby alleviating and curing disease. There are only a few acupuncture practitioners in Hawaii, many in Japan and the Orient, and at least one practicing on Harley Street in London.

In certain cases the needle may be left permanently in the body and show up in later years as a rather puzzling foreign body seen on a routine x-ray. Rarely they have been known to migrate into the abdominal cavity and perforate a viscus, necessitating an emergency laparotomy. The survival of acupuncture for thousands of years must mean that it is therapeutically effective when properly applied. For those who scoff and demand scientific proof of its efficacy, I would quote from Hamlet, who said "There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy."

The Concept of Pre-Death

This is the title of a thought-provoking study of the geriatric population in a large Scottish city (Lancet, May 29, 1971). As can be appreciated from the following excerpts, we share many of the same problems in attempting to provide for the medical needs of our own aged citizens.

"At the start of life the infant is unable to walk unsupported, to control his sphincters, and to formulate abstract concepts. At the close of life many people lack these same abilities. Society is well organized to nurture the child through maturation; but the prolonged dependency of the aged on the present scale is a new phenomenon, and it has created new needs in our society." "An outstanding feature was the extremely high proportion of old people who suffered from prolonged incontinence and mental abnormality in the months or years before their death, amounting to approximately a quarter of all who died after attaining the age of 65." "It seems that many of those who survive into old age enter a phase of "pre-death" in which they outlive the vigor of their bodies and the wisdom of their brains. The century which followed Darwin has yielded a new biological phenomenon: the survival of the unfittest." "This study has practical implications. One is that the diseases of pre-death—incontinence, dementia, arteriosclerotic brain disease and the like—should be thought of as among the outstanding public health problems of today." "Unless an enormously increased investment is made in hospital and domiciliary services for the aged or unless some new treatment becomes available

continued page 334

In Memoriam – Doctors of Hawaii

HAWAII MEDICAL JOURNAL

This is the ninety-first installment of In Memoriam—Doctors of Hawaii.

Chito Yamamoto

Chito Yamamoto was born on March 25, 1899, in Hilo, Hawaii. He was the son of Dr. Susumu and Ai Yamamoto. His father was a practicing physician in Hilo at that time.

Dr. Chito Yamamoto received his medical education in Japan. In 1924 he was graduated from the Nagasaki Medical College. He served as surgeon at the Kagoshima Hospital for one year. In 1929 he did special work in legal medicine at Nagasaki Medical College. In 1932 he took advanced work in gynecology at the same institution.

Returning to Hawaii in 1927, he practiced with his father at Haleiwa, Oahu. In 1929 he went back to Japan.

Dr. Yamamoto was drafted into the Japanese Army Medical Corps in 1944 and was killed while on active duty in the Philippines on February 13, 1945.

Howard W. Chamberlin

Howard W. Chamberlin was born in Minneapolis, Minnesota, on May 10, 1891. He was the son of W. E. and Effie (Smith) Chamberlin.

His elementary education was received in the schools of Minneapolis. He attended the Universities of Washington and Oregon and was granted his M.D. degree from the University of Oregon Medical School in 1926. Dr. Chamberlin served his internship at Seattle City Hospital.

On September 19, 1921, Dr. Chamberlin married Monta Cornelia Walters in Tacoma, Washington. One son, Robert Howard, was born to the couple.

Dr. Chamberlin arrived in Honolulu in July, 1927, as director of the Bureau of Tuberculosis. On October 1, 1928, he was appointed superintendent of the Kula Sanitarium at Waiakoa, Maui.

During the World War, Dr. Chamberlin served overseas in the U. S. Air Service for 21 months.

Golf, fishing and hunting were the doctor's hobbies.

On May 7, 1937, Dr. Chamberlin died in Honolulu within a few days of his 46th birthday.

He was a member of Sigma Nu fraternity, the Maui Country Club, Maui County and Racing Association, Maui Chamber of Commerce, and the Maui County Medical Society.

Alfred Leslie Craig

Alfred Leslie Craig was born June 30, 1895, at Long Beach, California, son of Robert John and Victoria (Ferguson) Craig. His father was one of Long Beach's first builders and contractors and an active worker in the First Methodist Church.

He was educated at the Long Beach High School and attended the University of Southern California for one year. His schooling was interrupted for active service as a pharmacist's mate in the U. S. Navy from May, 1917, to February, 1919. He received his Bachelor of Science degree from the University of Chicago in 1920.

On September 2, 1920, Dr. Craig married Hallie Marvin at the Sigma Nu fraternity house on the University of Chicago campus. The Craigs had four children: Robert Leslie, Elmyra, Marilyn, and James Marvin.

Rush Medical College in Chicago granted him his degree in medicine in 1923. His first year of internship was served at the Presbyterian Hospital in Chicago. Wishing to specialize in pediatrics, Dr. Craig spent one year on children's work at the Children's Hospital in Los Angeles.

After three months of pediatric practice in Long Beach, Dr. Craig developed a lung hemorrhage and spent the following year in bed at Tjunga, California, where he and Mrs. Craig lived in a small cottage. After a complete recovery, the doctor and his wife returned to Los Angeles where he became assistant to Dr. John C. Wilson, practicing orthopedics.

Dr. Wilson, who was very pleased with Dr. Craig's work, recommended him to the board of the Shriner's Hospital in Honolulu as chief surgeon. In this position, he served from February, 1927, to December, 1941, when he retired due to ill health. Dr. Craig maintained a private prac-

continued page 335

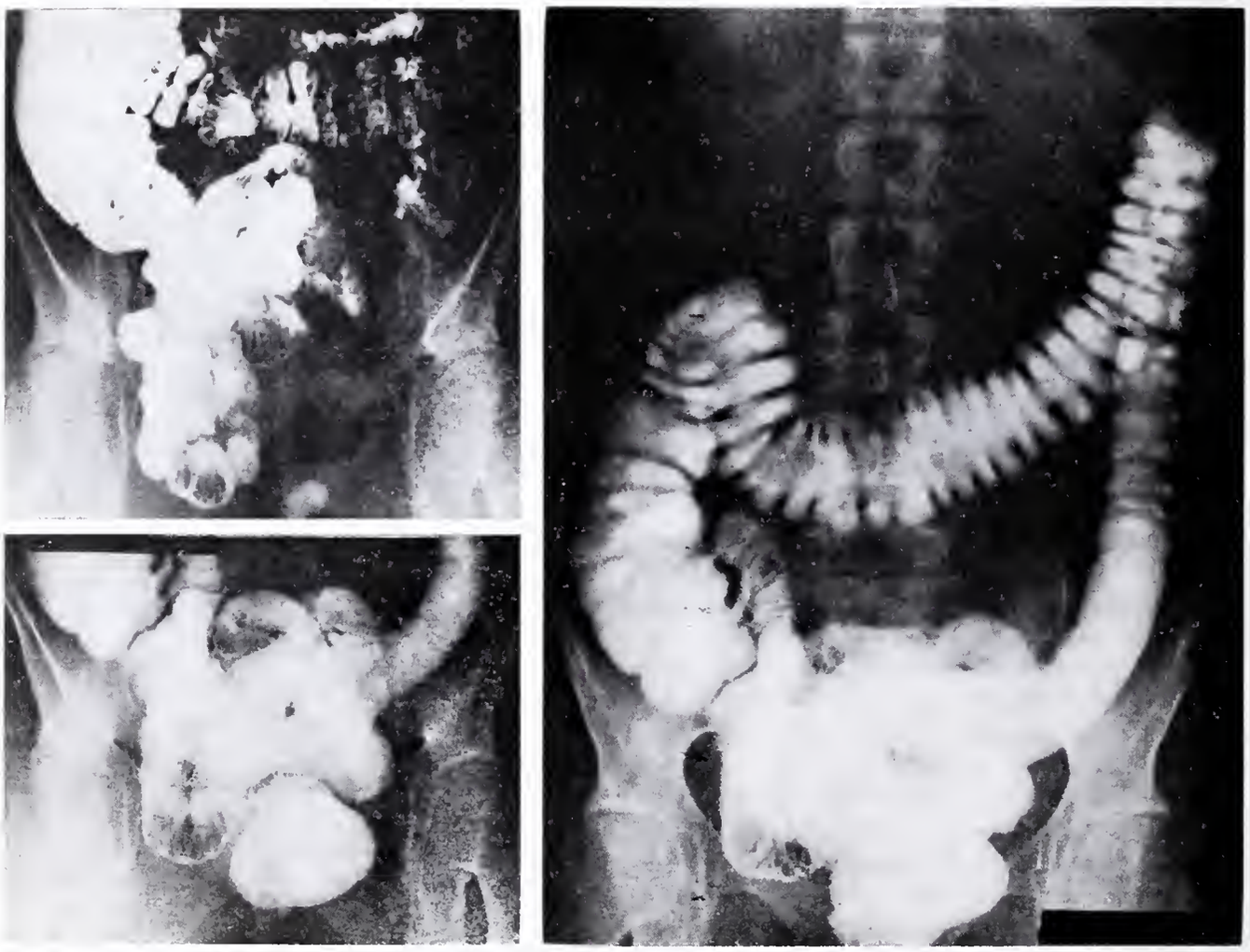
X-ray View Box

HAWAII MEDICAL JOURNAL

• A 31-year-old Hawaiian woman had a long history of "indigestion" and intermittent lower abdominal "colicky" type pain.

• At least two examiners felt a firm mass in her right lower abdominal quadrant at different times; however, this finding could not be consistently verified.

• What is your diagnosis?



Exploratory laparotomy and biopsy of the ileum disclosed only lymphoid hyperplasia with pigmentation to explain the filling defects noted within the distal ileum on both the barium enema examination and small bowel series. This could conceivably represent multiple recurrent intussusceptions.

Submitted by

D. R. Grininger, M.D.
Hawaii Radiological Society

Book Reviews

WINFRED Y. LEE, M.D.

HAWAII MEDICAL JOURNAL

★Morphology of the Blood and Marrow in Clinical Practice

By Richard T. Silver, M.D., F.A.C.P., New York, 125 pp., illus., Grune & Stratton, 1970.

THIS CONCISE, compact text on peripheral blood and bone marrow morphologic changes in hematological disorders emphasizes the clinical aspects of the problem. Of value in this book has been the simultaneous examination of both aspirated and closed-needle biopsy of bone marrow specimens. Unfortunately there are only 10 pages of colored photomicrographs, the rest being in black and white. Nevertheless, as a clear, basic simple text on the primary approach and study of the morphology of the cells in blood and bone marrow, this small text is an invaluable one.

ROBERT T. S. JIM, M.D.

Breathing: Hering-Breuer Centenary Symposium, A Ciba Foundation Symposium

Edited by Ruth Porter, 402 pp., illus., $14.95, J. & A. Churchill, 1970.

THE SYMPOSIUM arranged by the Ciba Foundation traces the history of study of the entire field of the nervous control of respiration from its origins in the works of Hering and Breuer on the "Self Steering of Respiration through the Nervus Vagus" in 1868, through the present time.

In this day of relatively sophisticated techniques in the field of respiratory physiology, such a thorough review of the nervous control of respiration as mediated through vagus, phrenic, chest wall, and central nervous system structures is a most interesting approach to the existing unknowns in the field of respiratory disease. The contributors to this symposium are among the world's most productive researchers in this field and they present original work which marries the fields of neurophysiology and pulmonary physiology into less separate disciplines. For the pulmonary physiologist the neurophysiologic principles explored in this symposium constitute a fresh approach and valuable addition to the understanding of clinical manifestations of pulmonary disease. Indeed, this publication sheds a great deal of light on the clinician's view of neurogenically mediated factors which serve to control respiration in both normal and abnormal states, and serves as a stimulating exercise in re-assessing one's approach to the evaluation of respiratory abnormalities from a basically experimental physiologic standpoint.

Each contributor's presentations are subjected to discussion by the participants at large and is presented in various sections of the book. These discussions are replete with current information, theory and potential clinical "pearls."

This publication should remain as an excellent reference to the store of knowledge accumulated in this field over the years.

PHILIP R. FOTI, M.D.

★ means highly recommended.

Mental Retardation—An Annual Review, II

Edited by Joseph Wortis, M.D., 228 pp., $14.75, Grune and Stratton, 1970.

THIS IS a highly readable review of current knowledge in the field of mental retardation. The book is divided into eleven sections, each by a competent authority (dermatoglyphics, neurology, nutrition, pedagogy, genetics, architecture, social work, parent organizations, etc.). The separate subjects are covered in varying depth but all are accompanied with exhaustive bibliographies. An excellent introduction by the editor discusses the definition of mental retardation and suggests separation of the biologically and psychosocially induced forms instead of the usual reliance on intelligence quotient. Controversial subjects such as the definition, testing, triage, and teaching of the retarded are debated openly throughout the book. As in all multiple-author texts, there is quite a bit of overlap and repetition, especially in the realm of genetics.

The sections on architecture and parent organization seemed excessively long while several clinical aspects were allotted little space. Several subjects were covered in great detail—well beyond the scope of an annual review (i.e. dermatoglyphics), but still requiring further reading for a real working knowledge of the field.

Despite these possible deficits the book can be highly recommended as "must" reading for pediatricians, neurologists and for those working in the field of retardation.

JORDAN S. POPPER, M.D.

★So You Have Glaucoma, 2d Ed.

By Everett R. Viers, M.D., 84 pp., illus., $5.75, Grune & Stratton, 1970.

THE SECOND EDITION of this well-written book, which is presented to the reader in lay terms and illustrated by diagrams of anatomical relationships, is important in the understanding of the glaucomas. This is a timely addition to aid the patient in his understanding of his disease.

To my knowledge, this is the first work of this kind; formerly ophthalmologists furnished such information in pamphlets made available by the Foundation for the Prevention of Blindness.

The author's background in ophthalmology is extensive, and I see no conflict between his explanations and the accepted views of the majority of ophthalmologists on the pathogenesis of the glaucomas. The chapter on treatment is diplomatically written, in that, aside from conventional methods of treatment used in the past, the ultimate decision is left to the individual ophthalmologist of the patient's choice.

I think the author wisely repeats the admonition of the importance of the patient following out instructions for treatment and frequent follow-ups. His conclusions that the disease is "controlled," rather than "cured" is certainly true and should give the patient psychological assurance of being helped.

PHILIP M. CORBOY, M.D.

continued page 354

Notes and News

HENRY N. YOKOYAMA, M.D.

HAWAII MEDICAL JOURNAL

Life in These Parts

In the aftermath of the tragic death from burns at Queen's came the following Kuakini Nursing Dept. memorandum:

"To Nursing Units:

Subject: Smoking.

Smoking is *not permitted* in bed.

Smoking is permitted in *private rooms* only in sitting position. *ie* must be fully awake.

Smoking is discouraged in semi-private rooms.

Patients who wish to smoke should use the lounge or lanai areas.

Visitors are not permitted to smoke in patients' rooms."

(Somehow we get the feeling that those poor ward patients are not allowed to smoke either sitting or standing.)

Our jester, **Ben Tom,** recently returned from a 2-week teaching tour in the Trust Territories, erupted with vesicular lesions of his right nasolabial fold. We inquired solicitously about the affliction and got the curt reply, "I have *yours.*" "My what?" we shot back, and he repeated. "I have *yaws.*" (But then it turned out to be just herpes simplex.)

Quotable Quotes

"Like trying to light a pail of water.' (**Grant Stemmerman,** expressing the ultimate in frustration during an oncology conference.)

"Everyone eventually reaches his level of incompetence." (**Ed Childs,** discussing the quality of personnel. This may sound like the Peter Principle, but Ed feels he enunciated it first.)

"Eating a good Pirie is like having an orgasm." (**George Suzuki,** mango connoisseur, on the relative merits of Haydens vs. Piries.)

Professional Moves

Astrologists in Burma claim that this Year of the Wild Boar will bring a good agricultural crop, plenty of fish, less warfare, and more prosperity, but lots of anxieties for the country's ministers, some disease among people, but fewer casualties, and a scarcity of salt and cloth, and people born this year will be of defective character . . . So be forewarned, ye believers . . .

In May, ENT man **Kazuo Teruya** left the Honolulu Medical Group and joined fellow ENT man **John Watson** and the Hawaii Ear, Nose & Throat Group Ltd., at Suite 330, Alexander Young Bldg. Eye man **Leonard Kuninobu** (son of the late James Kuninobu, and previously practicing in California) opened his office at Suite 411, Professional Center Bldg. Internist **Allan Leong** relocated to Room 207, 181 South Kukui Street.

June saw a flurry of activity. Eye man **Shigemi Sugiki** left the Straub Clinic and began solo practice at the Atlas Insurance Bldg., Suite 905. Surgeon **Charley Judd** left the confines of Leahi and relocated to 1741 Nuuanu Ave. (Keith Kuhlman's office). Internist **Sam Gresham** (who just finished his tenure as senior medical resident at Queen's) and cardiologist **John Davis** opened their joint offices at Pacific Grand Bldg., 747 Amana Street.

Going into July, cardiologist **Simeon Cheng** joined the Dixon-Bell Clinic, while his pathologist wife **Lina Lai-Ling Yu,** joined the Pathology Associates. Pediatrician **Wyman Tong** associated with **Henry Yim** at the Kaneohe Medical Bldg.

On the Health Dept. front, **Harry Lee Boyett** became the State's new epidemiologist, assuming the post vacated by the untimely death of Lloyd Guthrie. Among his many qualifications, we note a tour as medical officer aboard a National Science Foundation research vessel in the Antarctic. **Andrew Saekett,** commissioner of health in Boston, Mass., arrived in July to become administrator of Hale Mohalu, a vacancy created by **Joe Hathaway's** compulsory retirement last year.

Conference Humor

During a Children's Hospital noon conference on family planning for pediatricians, Ron Pion pointed out that the abortion rate at Kapiolani Hospital was about 180 per month and that 65% of the pregnancies resulted from not using contraceptive measures. With some levity, he pronounced, "Notwithstanding psychiatric studies, the majority of pregnancies in young girls are due to a lack of contraceptive measures rather than a subconscious desire to become mothers." Ron, a member of Zero Population Growth, admits his own 3 children were contraceptive failures and suggests that ¾ million births annually in the US are unwanted. A real factor appears to be the social pressure on the male to score as often as he can. Turning to drug store displays, Ron says, "Contraceptives can be displayed, but prophylactics cannot under Hawaii's laws and the condom is not recognized as a contraceptive, but as a prophylactic." When he further digressed into store displays of sanitary napkins as another factor, **Doris Jasinski** chided, "Is that why you went into Ob-Gyn? Because your mother sent you to the store to get sanitary napkins?" **Sam Waxman** announced that Kapiolani now offers the full gamut of services, viz, an infertility clinic, a sexual counselling clinic, a pregnancy testing service, and an abortion clinic. Our practical pediatrician, **John Marshall,** has his own practical contraceptive measure to offer: "I tell my teenagers that the strongest muscle in your body is the masseter and the next strongest, the muscles which bring your legs together."

During a Friday morning Queen's medical conference, the panel of hematologists discussed the treatment of hemophiliacs. We learned that Bantus have a high Factor VIII level and that Factor VIII levels are higher during pregnancy and exercise and in older persons. The trend being towards prophylactic AHF infusions, the demand for Factor VIII donors has increased and **Reg Ho** suggested, "Get an older woman who is pregnant and have her run up the stairs," whereupon **Bob Jim** added, "Preferably a Bantu woman." The repartee continued into the discussion of autoimmune antibodies interfering with AHF infusions. Reggie: "Why not get AHF from another species?" Bob: "Get AHF from a twin." Reggie cautioned, "The twin may have hemophilia too."

Overheard . . .

Daffynition of a braless gal: Titty titty bang bang (By Kuakini evening CCU nurse, Evelyn Chang.)

Hi-Lites of the Sportsman's Nite at WCC

We gormandized on the pre-dinner shrimp tempura, miniature sausages, fried chicken and **Al Ho's** round of free drinks. Al, happy as a lark at grossing a fabulous 74, was buying . . . Hunter **Bill Davis** described his Bow and Arrow Tournament on Hawaii. It seems that **Jim Cherry** had never used a bow and arrow but had borrowed Bill's 60-lb. bow. After stalking game for miles on end, Jim came face to face with an equally surprised 120-lb. boar. Quickly gathering his wits, Jim drew back on the bow, sighted carefully at point blank range and missed by a mile. When the angry boar fled into the brush, our brash hunter tried to give chase and had to be forcefully restrained. Chagrined, Jim declared that if he had only had a light on the front end and a magnifying glass on the back of the arrow (like a proctoscope), he would have gotten the boar right up its okole. Thereupon, Bill on returning to Honolulu, spent a feverish week installing steel feathers on one end of a two-foot chrome plated tube and a battery lighted bulb on the other for presentation to this intrepid hunter. Following this abortive hunting expedition, Bill, Jim, *et al* went fishing till 2 A.M., with Jim catching 20 large Mempachi and Bill 15. This of course, was more than all of our fishermen in the Fishing Tournament caught on that fateful tournament Sunday. During the presentation ceremonies, **Harold Sexton** described how two of the boats developed engine trouble; how **Dick Sakimoto** on his Kamome had a fish on, but a shark took it; how **Ted Tseu** also on the Kamome was whitewashed; how Harold in his own boat with **Bill Natoli** and **Herb Uemura** fished from 6 A.M. to 6 P.M. with nary a bite . . . The sum total of the catch for the entire fishing derby was a big fat zero. The tittering resolved into hilarious guffaws when Harold sheepishly announced, "All the prize money will be refunded . . ."

Paul Tamura, MC for the evening, described the golf tournament as a contest between the "good guys and bad guys." (Obviously all the "bad guys" won because we weren't among the winners) . . . Outgoing HMA prey **John Lowrey** was introduced as "the most relaxed person here tonight" (having finished his hectic term of office) and John presented his President's Trophy and the merchandise certificate to **Al Ho** for his 74-10-64, low net win. Al graciously acknowledged the encouragement by even his opponents, **Kenneth Fujii** et al, and the advice from his golf partner **Mae Mitsuda** "who is my greatest coach . . . he kept saying 'swing those hips!'" Shot maker **Sam Yee** shot a creditable 76-10-66 to win Low Gross and our Mid Pac ace **Frank Fukunaga** shot 82-15-67 for 2nd Low Net. Tied at 3rd with net 68 were **Allan Leong** and **Homer Izumi;** grouped at net 69 were **Mike Okihiro** and **Herman Mercado;** at net 70 were **Quintin Uy, Clarence Sakai** and our Ben Hogan disciple **Nobu Nakasone.** At net 71 were **Dick Chun** and **Don Maruyama** while at net 72 were **Dick Ho, B. Realica,** and **Mae Mitsuda.** At net 73 were bunched **Manuel Abundo, Kenneth Fujii, Herbert Takaki, Tom Fujiwara, Francis Oda, Paul Tamura, Ed Izawa** and **Coolidge Wakai. Sam Clark** shot a 126 for high gross honors. In his absence his golf partner **Francis Soong** stepped up to pick up Sam's prize, a book entitled, "How to Play Golf." Francis quipped, "Since I carried Sam all day, I'll accept the prize for him."

Varian Sloan was at his humorous best as he narrated the OCC matches. As expected, the traditional grand slam winner **Bill Dang** shot a 91-23-68 to win 1st place. **Jim Harrison** won low gross with a 79 and Varian was 2nd low net. At 3rd low net were **Ed Kagihara, Bill Stevens, Mark Sowers** and **Milt Trager.** High gross honors went to **Robert Ogawa** who happily accepted the telescopic putter designed for practice putting in his office.

5th Annual HMA Tennis Tournament

After raining steadily for three days and three nights, the downpour ceased "like a hundred million miracles," at exactly 6 A.M., Sunday, April 25. Someone up there heard us. As we splashed through rivulets and ponds enroute to the Kam School tennis courts we felt rather foolish, but committed. Surely, no one in his right mind would even bother to show . . . Yet, there was this familiar grey Porsche with the hulking figure of **Ted Tseu** nestled comfortably in it. Two eager beavers, **Bob Latta** and **John Balfour,** soon showed up and started to squeegee the court. Along came an exuberant **Don Jones** with two brand new brooms for sweeping the courts. **Charley Judd** brought the tournament roster neatly printed in mechanical drawing lettering. By 8:15 A.M., all twenty stalwarts were accounted for and despite all the dire predictions intoned especially by one **"Hunky" Chun,** by 9:30 A.M. the courts were playable. Spills were frequent in the shady moss-covered corners, but the games went fast and furious and by noon, the matches were over. The duo of **H. H. Chun** and **Gene Doo** (former Punahou ace) walked away with first place. The vaunted team of **Ben Tom** and **Charlie Ching** tied with the lucky team of **George Suzuki** and **H. Yokoyama** for 2nd place. We fail to understand how **Cal Sia** and **Hiro Tottori** slipped to 4th. **John Balfour** and **Bob Latta** made the cut off for the 5th place playoff with the Beretania contestants. We must remark that **George Kimata** and **Ted Tseu** made a superb effort and so did **Larry Gordon** and **Noberto Baysa.** In fact, we overheard Larry resolve, "Next year, Noberto and I will come in and *win.*" The duo of **Don Jones** and **Charley Judd** was voted the most enthusiastic and hilarious and the slower pacing combo of **Fred Gilbert** and **Mort Berk** the most troublesome. The team of **Jim Mertz** and **Winnie Chang** may have come in last, but showed the most potential for improvement . . .

The Beretania Courts were in excellent shape for the afternoon tournament and our sentimental favorites **Yutaka Yoshida** and **Leabert Fernandez** (whose ages add to 119) seemed to improve with age and copped first place through sheer talent, endurance, steadiness, and court savvy. Three teams tied for 2nd place: **Mits Yokoyama** and **Jordon Popper, Niali Seully** and **Bill Goebert,** and **Hau Vu** and **Bal Raj Mehta. Alex Roth** and **Shig Horio** barely made the cutoff. Again, what can we say for all those tough combos, **Bruce Joseph** and **Walt Shim, Victor Dizon** and **James Bennett, Howard Liljestrand** and **Richard Patterson, Virgil Jobe** and **Russ Carlson,** and **Simeon Cheng** and **S. Kurusu,** except that it just wasn't in the stars for them that day . . .

The playoffs for the Perpetual Trophy were held on yet another Sunday afternoon at Beretania and the **Yoshida-Fernandez** combo again proved as they have for the past five consecutive years that they were top dogs. The teams of **Ching-Tom** and **Horio-Roth** tied for 2nd place only 3 points behind . . . So back to the drawing boards again for another go next year. Some day, some place, a lucky team may yet replace this **Yoshida-Fernandez** combo for a berth on the HMA Perpetual Trophy . . .

Tom Thorson's Favorite Golf Anecdote

A just average golfer sliced his drive into the woods. In his search, he came upon a witch stirring her brew. Being a polite person by nature, he asked, "Madam, did

continued page 340

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

May 28, 1971—5:00 P.M.

Mabel Smyth Conference Room

PRESENT

Dr. Herbert Y. H. Chinn, presiding; Drs. William E. Iaconetti, John J. Lowrey, R. Varian Sloan, Thomas P. Frissell, George Mills, Theodore T. Tomita, Grover H. Batten, William W. L. Dang, H. William Goebert, Jr., Peter Kim, Ed. B. Helms, Sakae Uehara, George Goto, Coolidge Wakai, Charles Custer, J. Mark B. Sowers, Maurice Nicholson, Carl Lum, Don Poulson, B. Allen Richardson, Mrs. Sydney Fujita, Messrs. H. Tom Thorson, Tom Leineweber, and Jon Won.

MINUTES

ACTION:

It was voted to approve the minutes of the April 9, 1971, meeting as circulated.

COMMUNICATIONS NOT REQUIRING ACTION

The following communications were read:

(1) Letter from the Governor thanking the Hawaii Medical Association for its support of air quality standards. He informed the Association that standards will be adopted by the Department of Health and that public hearings will be conducted before adopting the plans.

(2) Letter from the University of Hawaii, School of Public Health, re their report to the State Legislature on a study of the first 9½ months of legal abortion in Hawaii. The School expressed appreciation for the cooperation of the medical profession during this period.

(3) Letter from Fred V. Hein, Ph.D., AMA Director, relative to the 13th National Conference on Physicians and Schools, in Chicago, September 30 through October 2, 1971.

(4) Letter from Elizabeth McNaughton, M.D., Assistant Director, Department of Mental Health, relative to a conference on "Mental Health Services in the General Hospital," in Reno, Nevada, July 7-9, 1971.

(5) Announcement of conference on "Prospects for Change in Hawaii's Patient Care Services" at the Hawaii State Capitol, June 10, 1971, sponsored by the National Commission for the Study of Nursing and Nursing Education.

(6) Letter from Dr. Rowlin Lichter relative to a proposal to initiate practical post-graduate training of the Molokai physicians.

ACTION:

It was voted to refer the proposal to the Maui County Medical Society to check with the Molokai physicians.

(7) H.R. No. 226: Relating to a conference on health manpower planning. A mandate from the Legislature that the Continuing Health Education Council of Hawaii, with the cooperation and assistance of all health and health professional organizations, plan and direct a conference on health manpower planning in the fall of 1971.

(8) H.R. No. 319: Requesting the Governor, the agencies of State Government, and the private sector to establish a comprehensive program to combat venereal disease.

COMMUNICATIONS REQUIRING ACTION

(1) Letter from Nancy Rogers of the AMA Field Office requesting that HMA, with the endorsement from Senator Fong, Congressman Matsunaga, and Congresswoman Mink, respond favorably to sponsorship of Medicredit, a bill submitted by AMA for a national health insurance based on certain income tax credits.

ACTION:

It was voted to refer the matter over to the National Legislative Committee for further study and to come up with an appropriate package that HMA can support.

(2) Letter from Hawaii Chapter, American College of Surgeons, and letter from Society of Internal Medicine, both letters requesting active participation in peer review.

ACTION:

It was voted "to send a letter to the two organizations informing them that the Peer Review Committee is in the process of being set up, that when the committee structure is completed they will be invited to participate in its deliberations."

(3) Letter from Dr. Ernesto M. Espaldon requesting HMA assistance in the Guam Medical Society's desire for membership in AMA.

ACTION:

It was decided that HMA shall encourage Guam to explore possible membership in AMA.

REPORT OF THE TREASURER

ACTION:

It was voted to approve the Treasurer's report subject to audit.

REPORTS OF THE COMMISSIONS AND SPECIAL COMMITTEES

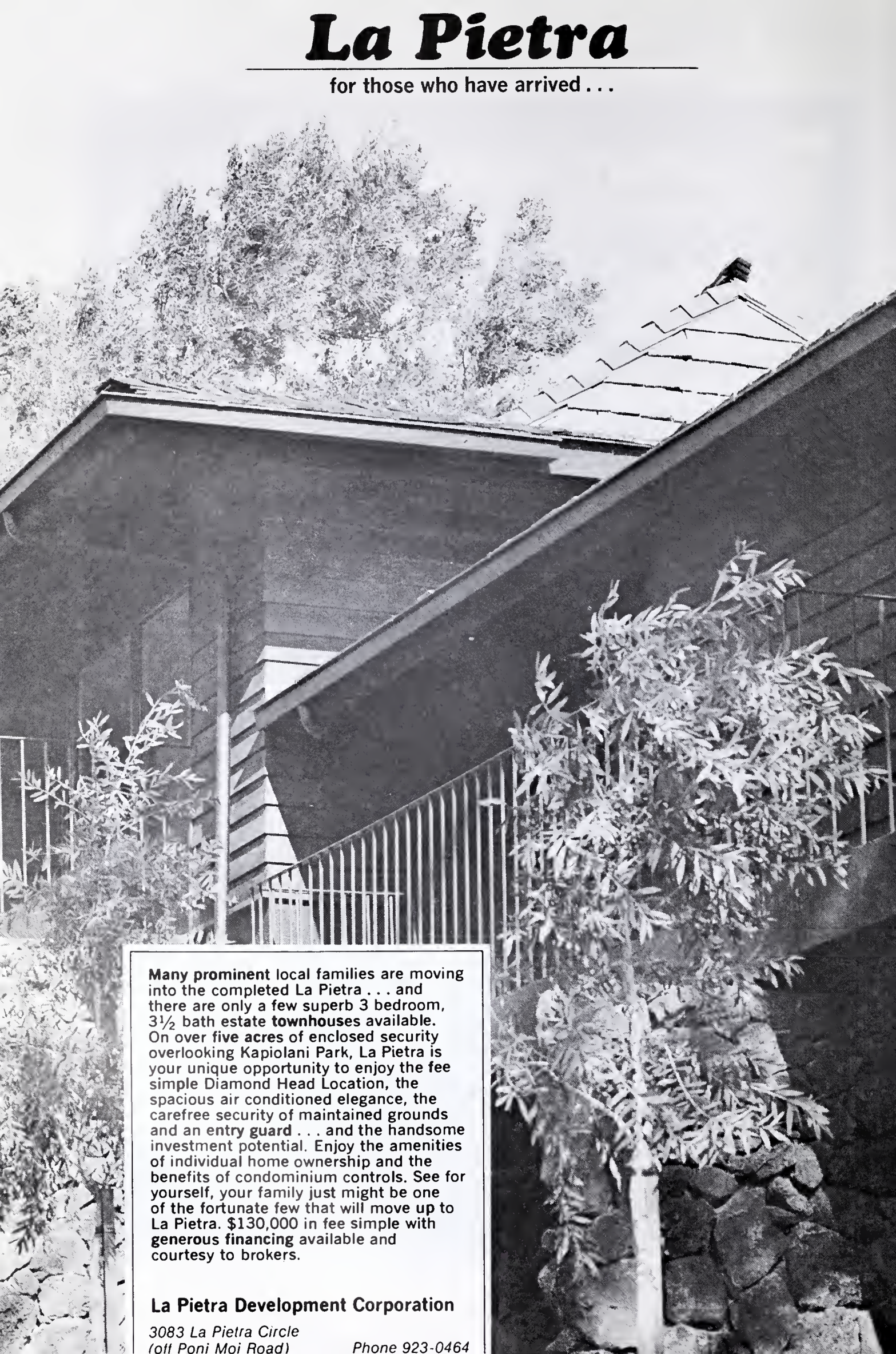
Site Approval for 1972 Annual Meeting: Dr. Wakai stated that the Arrangements Committee, after due deliberations and with the recommendaton from Mr. Harold Brown (Special and Professional Programs at the University of Hawaii College of Continuing Education and Community Service) decided to recommend to the Council that the 1972 Annual Meeting be held again at the Ilikai Hotel, this time reserving the entire Pacific Ballroom. Although there were no objections to the Ilikai, it was felt that a written comparison of the different facilities should be made.

continued page 344


Thorazine®
brand of chlorpromazine
versatility
quality
experience
NOW
THERE'S PRICE
Smith Kline & French Laboratories SKF

La Pietra

for those who have arrived . . .



Many prominent local families are moving into the completed La Pietra . . . and there are only a few superb 3 bedroom, 3½ bath estate **townhouses** available. On over **five acres** of enclosed security overlooking Kapiolani Park, La Pietra is your unique opportunity to enjoy the fee simple Diamond Head Location, the spacious air conditioned elegance, the carefree security of maintained grounds and an entry **guard** . . . and the handsome investment potential. Enjoy the amenities of individual home ownership and the benefits of condominium controls. See for yourself, your family just might be one of the fortunate few that will move **up** to La Pietra. $130,000 in fee simple with **generous financing** available and courtesy to brokers.

La Pietra Development Corporation

3083 La Pietra Circle
(off Poni Moi Road) *Phone 923-0464*

New Members

HAWAII MEDICAL JOURNAL



Peter A. Fleming, M.D.
P. O. Box 638
Kealakekua, Hawaii 96750
OBSTETRICS—GYNECOLOGY
George Washington University—1961
Internship—Barnes Hospital,
St. Louis, Missouri—1961-1962
Residency—Yale University—
1965-1968



Arthur M. Pettler, M.D.
Box 272
Hanapepe, Kauai 96716
INTERNAL MEDICINE
University of California, San
Francisco—1940
Internship—Los Angeles County
Hospital—1939-1941
Residency—Los Angeles County
Hospital—1941-1944



Alexander Cranston Peat
502 Pauoa Street
Lahaina, Maui 96761
PEDIATRICS
University of Michigan—1945
Internship—Lutheran Hospital,
Cleveland, Ohio—1945-1946
Residency—Brooke Army Hospital,
San Antonio, Texas—1948-1950



Robert J. Latta, M.D.
888 South King Street
Honolulu, Hawaii 96813
ADOLESCENT MEDICINE
Loma Linda University—1964
Internship—L. A. County General
Hospital—1964-1965
Residency—L. A. County General
Hospital—1965-1966
University of Washington—1968-1969



Harry L. Hinson, M.D.
1301 Punchbowl Street
Honolulu, Hawaii 96813
PSYCHIATRY
Harvard Medical School—1954
Internship—USPHS Hospital,
Staten Island, N.Y.—1954-1955
Residency—Kaneohe, Hawaii;
Queen's Hospital—1956-1959
Chestnut Lodge, Rockville, Maryland
—1959-1962



Leonard S. Kuninobu, M.D.
1481 South King Street
Honolulu, Hawaii 96814
OPHTHALMOLOGY
Loma Linda University School
of Medicine—1957
Internship—Los Angeles County
General Hospital—1957-1958
Residency—Los Angeles County
General Hospital—1958-1961



Our New President

At the tender age of 50 years, Honolulu-born urologist Herbert Y. H. Chinn became president of the Hawaii Medical Association for 1971-72. He had been installed as president-elect by AMA President Gerald Dorman on May 9, 1970.

Herbie has gone the route of the good medical citizen to reach this honored post. A University of Hawaii graduate, he received his M.D. from Boston University School of Medicine in 1944, and his training in urology at Kings County Hospital; from there he went to 2½ years of Army duty, 1947 to 1949.

He returned to Hawaii at the end of 1952 and joined the Honolulu County Medical Society, where he immediately assumed committee responsibilities with which he continued to be involved during the subsequent years. In 1963 he became treasurer of the County Society; in 1963 he was elected as Hawaii Medical Association treasurer. In 1968, he was president of the Board of Governors of the Honolulu Foundation for Medical Care, and the Honolulu County Medical Society. He is a past president of the See Dai Doo Society. And so far as we know he is the first State medical association president of Chinese ancestry.

Herbie has played a leading part in the development of Honolulu's foremost hemodialysis and renal transplantation program, at St. Francis Hospital. A less inscrutable man might take more ostentatious pride in being part of such a community effort. He doesn't parade his feelings.

He's a good family man, so good that he was named Father of the Year in Medicine by the Chamber of Commerce of Hawaii in 1966. He was married in 1950 to Una Chuh and they have six children, Patricia (20), Herbert, Jr. (18), Barbara Ann (16), Stephen (14), Wendy (13), and Eric (12).

He prides himself, quietly, on his skill with a Chinese smoke barrel, a talent he may have inherited, since a relative of his formerly owned and operated the Red Rooster chop suey restaurant.

He has developed a keen and informed interest in antiques, and collects them at home.

He is a no-nonsense administrator, with firm ideas about his appointments and activities, and already has one team-managed triumph to his credit, the grant award for the Hawaii Experimental Medical Care Review Organization (HEMCRO).

Welcome to our top job, Herb!

Index to the 1971 Proceedings of the House of Delegates

Special Reports

County Society Reports
- Hawaii 315
- Honolulu 316
- Kauai 316
- Maui 316

Officers
- President 310
- Secretary 311
- Treasurer 313

Appointees
- Legal Counsel 314
- Legislative Counsel 314
- Mabel Smyth Board 315

Additional Reports
- AMA Delegate 319
- Woman's Auxiliary 332
- Community Research Bureau 320
- Executive Director 317
- HAMPAC 321

Commission Reports

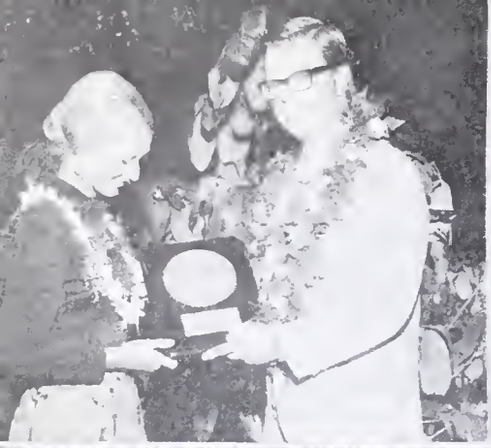
- Commission on Education & Scientific Research 319
- Commission for Internal Affairs 328
- Commission on Legislation 310
- Commission on Medical Services 320
- Commission on Public Health 307
- Commission on Public & Interprofessional Relations 327

Committee Reports

- AMA Clinical Session, Ad Hoc 318
- AMA-ERF 318
- Adjudication 318
- Arrangements 324
- Association of Professions 325
- Automotive Safety 300
- Awards & Special Projects 325
- Bureau of Research and Planning 307
- Bylaws and Parliamentary 307
- Cancer 300
- Cancer Commission 301
- Careers 325
- Chronic Illness & Aging 301
- Communicable Dis. & Imm., VD & TB 301
- Community Health Services, Ad Hoc 310
- Crippled Children 320
- Diabetes 302
- Disaster 302
- Drug Abuse, Ad Hoc 302
- Environmental Health 304
- Fee Survey 321
- Filipino Speakers Bureau 326
- Finance 307
- Health Manpower 326
- Heart 304
- Hospital 321
- Indigent Medical Care 321
- Japanese Speakers Bureau 326
- Legislative 309
- Maternal and Perinatal Mortality Study 305
- Medical Care Plans 322
- Medical Education 322
- Medicine and Religion 328
- Mental Health 305
- National Legislation 309
- Negotiating 323
- News Media 328
- Nominating 333
- Operation Pacific 329
- Peer Review 322
- Pharmacy 323
- Professional Liability Insurance, Ad Hoc 309
- Publications 330
- Public Relations 329
- Quackery 329
- Radiation 306
- School Health 306
- Scientific Program 330
- TV-Radio 331
- Water Safety 306
- Woman's Auxiliary 331
- Workmen's Compensation 323

Resolutions

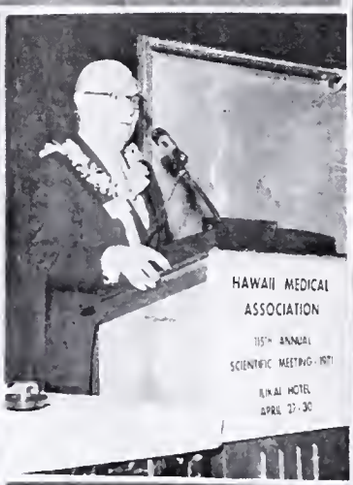
- No. 1—Publication of Article on "Changing Concepts of Death" 333
- No. 2—The 1970 Relative Value Studies 324
- No. 3—Peer Review 324
- No. 4—HMA Membership for Qualified Osteopathic Physicians 333
- No. 5—Bylaws 317
- No. 6—Assistant to the President 318
- No. 7—HMA Study on Quality of Personal Medical Care 318

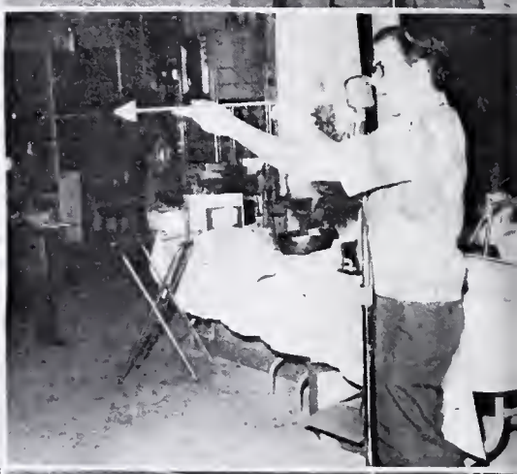









HAWAII MEDICAL
ASSOCIATION
115TH ANNUAL
SCIENTIFIC MEETING - 1971
ILIKAI HOTEL
APRIL 27-30




Just one injection
may provide
prolonged relief
or up to a month's
therapy

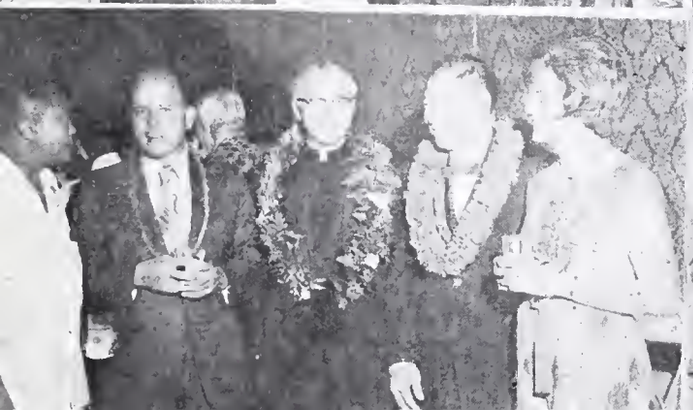













C. & V
Geig

115TH ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

HONOLULU, HAWAII

April 27 - May 1, 1971

The annual meeting for the one hundred and fifteenth year of corporate existence of the Hawaii Medical Association was held in Honolulu in 1971. The following program was presented:

SCIENTIFIC PROGRAM

PAPERS

Obesity: Prevention and Treatment
Peter H. Forsham, M.D.

The Modern Treatment of Diobetes Mellitus
Peter H. Forsham, M.D.

Serologicol Phenomena in Rheumotoid Arthritis
Morris Ziff, M.D.

Molignont Melanama, Clinical Aspects and Management
John S. Stehlin, Jr., M.D.

Etiologicol Aspects of Rheumotoid Arthritis
Morris Ziff, M.D.

The So-Called Variants of Rheumataid Arthritis
Morris Ziff, M.D.

Intersex
Peter H. Forsham, M.D.

Regional Chematherapy far Cancer
John S. Stehlin, Jr., M.D.

Phychological Aspects af Cancer—
To Tell or Nat ta Tell
John S. Stehlin, Jr., M.D.

Chronic, Painful, Disabling Prablems of the Faot
Rene Cailliet, M.D.

Why Me? Camman Behavior Problems in Children with Chronic Disease
John F. McDermott, Jr., M.D.

Old Skin, New Skin—Blue Skin, Red Skin
Norman Goldstein, M.D.

A Rational Approoch to the Treotment of Hypertension
Frank A. Finnerty, Jr., M.D.

Anatomicol Biomechanicol Aspects of Joints and Their Relotionship to Disease
Rene Cailliet, M.D.

Diagnostic Approach to Pleurol Effusian
Kenneth M. Moser, M.D.

Asparaginase in Cancer Therapy
Joseph H. Burchenal, M.D.

Symptoms ond Treatment af Lumbar Discogenic Disease
Rene Cailliet, M.D.

Presidential Address
John J. Lowrey, M.D.

AMA Presidential Address
Walter C. Bornemeier, M.D.

Treatment af Acute Hypertensive Crisis
Frank A. Finnerty, Jr., M.D.

Diagnosis and Management af Chranic Obstructive Lung Disease
Kenneth M. Moser, M.D.

Areas of Promise in Cancer Prablems
Joseph H. Burchenal, M.D.

Management of Tuberculosis
Kenneth M. Moser, M.D.

New Frantiers in Pulmonary Medicine
Kenneth M. Moser, M.D.

Differential Diagnasis of Hypertensian in Pregnancy
Frank A. Finnerty, Jr., M.D.

Burkitt's Tumor and Its Implication ta Cancer
Joseph H. Burchenal, M.D.

SOCIAL PROGRAM

Banquet, Pacific Ballroom, Ilikai Hotel
Sportsmen's Night, Waialae Country Club

MEETINGS

House of Delegates, Ilikai Hotel
Fireside Chats, Ilikai Hotel
Woman's Auxiliary, Waikiki Beachcomber Hotel

PARTICIPATING DELEGATES

Hawaii County
DeWitt H. Smith
R. P. Wipperman
Timothy D. Woo

Kauai County
Peter Kim

Maui County
John F. Morris
A. Y. Wong

Honolulu County
Douglas B. Bell, II
James G. Bennett
Max G. Botticelli
Ann B. Catts
Winfred Y. K. Chang
H. H. Chun
Cesar B. DeJesus
Frederick A. Dodge
George M. Ewing
Bernard W. D. Fong
H. William Goebert, Jr.
Walter H. K. Watt
Arthur K. Wong
Livingston M. F. Wong

Past Presidents
Samuel D. Allison
Harry L. Arnold, Jr.
F. J. Pinkerton
O. D. Pinkerton
Theodore T. Tomita
Samuel L. Yee
George Goto
Reginald C. S. Ho
Richard K. B. Ho
Gordon Liu
Willard Y. Miyahira
Michael M. Okihiro
William H. Sage
Niall M. Scully
Calvin C. J. Sia
Benjamin C. K. Tom
Frederick B. Warshauer
Philip H. F. Watt

REFERENCE COMMITTEES

Public Health
Douglas B. Bell II
Chairman
Calvin C. J. Sia
Reginald C. S. Ho
Willard Y. Miyahira
John F. Morris

Insurance and Medicol Services
William W. L. Dang
Chairman
Benjamin C. K. Tom
Niall M. Scully
Winfred Y. K. Chang
Timothy D. Woo

Parliamentary Affairs
Ann B. Catts
Chairman
George Goto
George M. Ewing
Walter H. K. Watt
Yonemichi Miyashiro

Miscellaneaus Business
Max G. Botticelli
Chairman
Richard K. B. Ho
H. William Goebert, Jr.
Livingston M. F. Wong
DeWitt H. Smith

HAWAII MEDICAL ASSOCIATION—Committees 1970-71

COMMISSIONERS

George Goto.....COMMISSION ON LEGISLATION
Cesar De Jesus.....COMMISSION ON PUBLIC AND INTERPROFESSIONAL RELATIONS
John R. Watson.....COMMISSION ON MEDICAL SERVICES
Winfred Y. Lee.....COMMISSION ON EDUCATION AND SCIENTIFIC RESEARCH
Calvin C. J. Sia.....COMMISSION ON PUBLIC HEALTH
Coolidge S. Wakai.....COMMISSION FOR INTERNAL AFFAIRS

AMA-ERF Committee

Robert T. S. Jim, Chairman (1971)
Windsor Cutting (1973)
Bal Raj Mehta (1972)
Sorrell H. Waxman (1971)
Winfred Y. Lee, Commissioner
R. P. Henderson (Hawaii) (1972)
M. A. Brennecke (Kauai) (1973)
Billie Fern Strother (Maui) (1971)

Adjudication Committee

Roy I. Iritani, Chairman (1971)
Kenneth Chinn (1971)
Albert C. K. Chun-Hoon (1971)
William W. L. Dang (1973)
Bernard W. D. Fong (1973)
Clarence S. Sakai (1973)
John R. Watson, Commissioner
R. P. Wipperman (Hawaii) (1971)
Samuel R. Wallis (Kauai) (1972)
K. B. McCollum (Maui) (1973)

Arrangements Committee

R. Varian Sloan, Chairman (1973)
William Davis (1973) (Bow & Arrow)
Takeo Fujii (1973) (Golf)
Charles Judd (1973) (Tennis)
Donald Maruyama (1972) (Sportsmen's Night)
Bal Raj Mehta (1973) (Tennis)
Andrew L. Morgan (Fishing) (1972)
Daniel J. Newhill, Jr. (1973) (Bow & Arrow)
Arnold Siemsen, ex officio
John Smith (1973) (Banquet)
Theodore T. Tomita (Banquet) (1972)
Henry N. Yokoyama (1973) (Tennis)
Coolidge S. Wakai, Commissioner
George Bracher (Hawaii) (1973)
Eugene Rames (Kauai) (1973)
K. B. McCollum (Maui) (1971) Resigned

Association of Professions Committee

Leabert R. Fernandez, Chairman (1973) Resigned
Samuel Allison (1973)
Ralph B. Berry (1972)
Ellis Devereux (1971)
Ralph R. Sachs (1972) Resigned
Leigh Sakamaki (1972)
Stephen H. Tenby (1971)
Cesar De Jesus, Commissioner
Etta W. Best (Hawaii) (1972)
Joan J. Takeuchi (Kauai) (1973)
Billie F. Strother (Maui) (1971)
Sakae Uehara (Maui) (1973)

Automotive Safety Committee

Truett V. Bennett, Chairman (1973)
Francis T. C. Au (1973)
Ralph B. Berry (1972)
Roger Brault (1972)
Ralph Cloward (1973)
William J. T. Cody (1972)
Raymond C. Dusendschon (1972)
Bernard W. D. Fong (1972)
William H. Gulledge (1972)
Carl E. Johnsen, Jr. (1971)
Arthur V. Molyneux (1972)
Michael M. Okihiro (1971)
Ralph Sachs (1973) Resigned
Robert L. Smith (1971)
Garton Wall (1973)
Patrick J. Walsh (1972)
Bernice Walters (1973)
Calvin C. J. Sia, Commissioner
Haruto Okada (Hawaii) (1972)
Burt O. Wade (Kauai) (1973)
James F. Fleming (Maui) (1971)

Awards and Special Projects Committee

K. S. Tom, Chairman (1973)
Max G. Botticelli (1971)
William J. Holmes (1972)
Robert T. S. Jim, Vice Chairman (1973)
Harold M. Johnson (1971)
Bunzo Nakagawa (1972)
Warren L. H. Wong (1971)
Coolidge S. Wakai, Commissioner
Barton Eveleth (Hawaii) (1972)
A. C. Johnston (Kauai) (1973)
John F. Morris (Maui) (1971)

Bureau of Research and Planning Committee

J. I. F. Reppun, Chairman (1973)
Samuel D. Allison (1972)
Richard K. Blaisdell (1972)
Claude Caver (1973)
Cesar B. De Jesus (1972)
Lawrence H. Gordon (1973)
Victor Hay-Roe (1971) Resigned
George Henry (1973)
Robert L. Kistner (1972)
Rowlin L. Lichter (1972) Resigned
Wilbur S. Lummis (1971)
Richard T. Mamiya (1973)
James L. Mertz (1972)
Robert W. Peyton (1972)
Ralph R. Sachs (1972) Resigned
Theodore T. Tomita (1972)
R. P. Wipperman (Hawaii) (1971)
Casper F. Rea (Kauai) (1972)
J. M. B. Sowers (Maui) (1973)

Bylaws and Parliamentary Committee

Harry L. Arnold, Jr., Chairman (1973)
Richard Dang (1973)
Cesar B. De Jesus (1971)
Carl H. Lum, Vice Chairman (1973)
Wilbur S. Lummis (1971)
Roscoe S. Pebley (1972)
Alexander Roth (1973)
Dudley Seto (1973)
Clarence Y. Sugihara (1972)
Coolidge S. Wakai, Commissioner
H. E. Crawford (Hawaii) (1971)
Yonemichi Miyashiro (Kauai) (1972)
Sakae Uehara (Maui) (1973)

Career Committee

Thomas K. L. Lau, Chairman (1973)
Samuel D. Allison (1973)
Stanley Batkin (1971)
Ralph B. Berry (1972) Resigned
Richard K. Blaisdell (1973)
Carl Boyer (1973)
Thomas C. Brown (1971)
Hans W. Graumann (1971)
Meryl H. Haber (1972)
Reginald C. S. Ho (1972)
Edward L. S. Jim (1973)
John P. Keenan (1972)
Glenn M. Kokame, Vice Chairman (1971)
John Krieger (1972)
Wayne S. Limber (1971)
Carl H. Lum (1972)
Noboru Oishi (1973)
Robert H. Oishi (1971)
Stanley Saiki (1972)
I. L. Tilden (1972)
George Bracher (Hawaii) (1971)
Casper F. Rea (Kauai) (1972)
Jose Romero (Maui) (1973)
Grover H. Batten, Cancer Commission Rep.
Drake Will, Cancer Commission Rep.
Calvin C. J. Sia, Commissioner

Careers Committee

Robert W. Noyes, Chairman (1971) Resigned
Stanley Batkin (1972)
John Ronald Brown (1972)
Walter W. Y. Chang (1973)
Ellis F. Devereux (1973)
Martha Lou Hefley (1973)
Masaru Koike (1971)
Ivar J. Larsen (1972)
Lawrence Lau, Jr. (1973)
R. Reginald Patterson (1972)
William T. Won (1972)
James Young (1972)
Walter K. W. Young (1972)
H. Wm. Goebert, Jr. Chairman (1972)
James A. Mitchel (Hawaii) (1971)
Robert Hamblin (Kauai) (1972)
Jose Romero (Maui) (1973)

Chronic Illness and Aging Committee

L. Clagett Beck, Chairman (1973)
Arthur V. Molyneux (1972)
Shigeo Natori (1972)
B. E. Realica (1972)
Kleona Rigney (1971)
Ralph R. Sachs (1972) Resigned
Dudley Seto (1973)
R. Frederick Shepard (1972)
Calvin C. J. Sia, Commissioner
Norman R. Sloan, Vice Chairman (1972)
Herbert Wong (1973)
Eugene D. Rames (Kauai) (1971)
Kenneth Haling (Maui) (1972)

Communicable Disease & Immunization, Venereal Disease & Tuberculosis Committee

L. T. Chun, Chairman (1973)
Samuel Allison (1973)
L. Clagett Beck (1973)
Claude V. Caver (1972)
Donald F. B. Char (1973)
Richard W. M. Dang (1971)
Ira D. Hirschy (1972)
Noboru Oishi (1973)
Roscoe S. Pebley (1972)
Betty Soo (1972)
Hiroaki Tottori (1973)
Kirsten Vennesland (1972)
Raymond J. C. Wong (1971)
Calvin C. J. Sia, Commissioner
Walter E. Batchelder (Hawaii) (1972)
Katok A. Chuang (Kauai) (1973)
John Francis Morris (Maui) (1971)

Crippled Children Committee

Robert Bart, Chairman (1973)
Louise S. Childs (1971)
George M. Ewing (1973)
William H. Guneoge (1972)
Richard B. Joseph (1971)
Roy M. Kaye (1971) Resigned
George Kenessey (1971)
Ivar J. Larsen (1973)
Carl Lehman (1973)
Alfred D. Morris (1972)
Frances Nakamura (1973)
Herbert Nakata (1973)
L. Q. Pang (1971)
Alan Pavel (1971)
Jordan S. Popper (1971)
Walton K. T. Shim (1971)
Betty S. M. Soo (1972)
Kazuo Teruya (1972)
Coolidge S. Wakai (1971)
John R. Watson (1971)
Raymond J. C. Wong (1971)
Ronald Yamaoka (1973)
Calvin C. J. Sia, Commissioner
M. L. Chang (Hawaii) (1972)
Katok A. Chuang (Kauai) (1971)
Denis Fu (Maui) (1972)

Diabetes Committee

Willard Y. Miyahira, Chairman (1973)
Anna Marie Brault (1972)
David T. Eith (1973)
Fred Goff (1973)
Francis Ikezaki (1971)
George Kenessey (1972) Resigned
Kleona Rigney (1973)
Louis G. Stuhler (1971) Resigned
Sorrell Waxman (1973)
Calvin C. J. Sia, Commissioner
Walter S. L. Loo (Hawaii) (1973)
Peter Kim (Kauai) (1971)
A. Y. Wong (Maui) (1972)

Disaster Committee

Millard S. L. Seto, Chairman (1973)
Ralph Berry (1973)
Roger Brault (1972)
Ellis F. Devereux (1971)
Casimer Jasinski (1973)
Joseph T. Lucas (1972)
Edmund C. K. Lum (1971)
Rodman B. Miller (1971)
R. S. Pebley (1972)
Maurice L. Silver (1971)
Louis G. Stuhler (1972) Resigned
Garton Wall (1973)
Daniel Whang (1973)
Cesar De Jesus, Commissioner
James K. Matayoshi (Hawaii) (1973)
Burt O. Wade (Kauai) (1971)
John N. Withers (Maui) (1972)

Environmental Health Committee

James L. Erickson, Chairman (1972)
Truett V. Bennett (1973)
Thomas C. Brown, Jr. (1971)
Cesar B. De Jesus (1972)
Raymond Dusendschon (1973)
William Philip Grice Jones (1971)
Charles S. Judd, Jr. (1972)
Wilbur S. Lummis (1973)
Laurence J. McCarthy (1971)
George H. Mills (1972) Resigned
Alfred Dyer Morris (1973)
Robert W. Peyton, II (1971)
Leigh Sakamaki (1972)
Calvin C. J. Sia, Commissioner
R. Frederick Shepard (1973)
James T. S. Wong (1971)

Fee Survey Committee

Frederick B. Warshauer, Chairman (1971)
Daniel Bessesen (1973) Resigned
Edward W. Boone (1971)
William G. Davis (1972)
Raymond deHay (1973)
David A. Fisher (1973) Resigned
Takakazu Fukumura (1972)
Ralph Hale (1973)
Kiyoshi Inouye (1973)
Elmer Johnson (1971)
Roy M. Kaye (1972) Resigned
Carl Lehman (1973)
Gail G. L. Li (1972)
Laurence McCarthy (1973)
Maurice W. Nicholson (1971)
Noboru Oishi (1973)
L. Q. Pang (1973)
O. D. Pinkerton (1971) Resigned
Francis Soon (1973)
Jerome L. Tucker (1971)
Garton Wall (1973)
Herbert Wong (1973)
Allan H. W. Young (1972)
John R. Watson, Commissioner
W. S. Kasamoto (Hawaii) (1972)
Samuel R. Wallis (Kauai) (1973)
W. E. Iaconetti (Maui) (1971)

Filipino Speakers Bureau

Manuel A. Abundo, Jr., Chairman (1973)
Gloria N. Badua (1971)
Mario P. Bautista (1973)
Norberta Baysa (1973)
Corazon A. Manayan (1973)
Henry A. Manayan (1971)
Buenaventura E. Realica (1972)
Arturo F. Salcedo (1973)
Ernesto M. Santos (1971)
Quintin Uy (1973)
Cesar De Jesus, Commissioner
Gonzalo Geroso (Kauai) (1973)
Jose Romero (Maui) (1971)

Finance Committee

Thomas P. Frissell, Chairman
M. J. Avecilla (1972)
Robert Chung (1973)
William W. L. Dang (1973)
Kiyoshi Inouye (1971)
Richard Moore (1973)
Theodore T. Tomita (1972)
Robert Berry (Kauai County Treasurer)
Elmer C. Johnson (1972) (HCMS Treas.)
Allan S. Takase (Hawaii County Treas.)
John N. Withers (Maui County Treas.)

Health Manpower Committee

H. H. Chun, Chairman (1972)
Jeanette Chang (1973)
William G. Davis (1971)
Mary A. Glover (1972)
H. Wm. Goebert, Jr. (1973)
Victor Hay-Roe (1973)
William H. Hindle (1972)
Arthur V. Molyneux (1972)
Robert H. Oishi (1971)
Cesar De Jesus, Commissioner
Tokuso Taniguchi (Hawaii) (1972)
Robert Emrick (Kauai) (1973)
Joseph E. Andrews (Maui) (1971)

Heart Committee

John F. Hanley, Chairman (1971)
Edward L. Chesne (1971)
Bernard W. D. Fong (1972)
Unoji Goto (1973)
George W. Henry (1972)
Wallace W. S. Loui (1972)
Richard T. Mamiya (1973)
Rodman B. Miller (1971)
George Nagao (1972)
Niall M. Scully (1972)
Coolidge S. Wakai (1973)
Robert Weiner (1971)
Calvin C. J. Sia, Commissioner
Reginald S. Carvalho (Hawaii) (1972)
Eugene Rames (Kauai) (1973)
DeWitt H. Smith (Hawaii) (1973)
Bertram A. Weeks (Maui) (1971)

Hospital Committee

Robert K. Mookini, Jr., Chairman (1972) Resigned
Ralph B. Berry (1973)
Philip T. Chu (1972) Deceased
William W. L. Dang (1971)
William H. Hindle (1973)
Carl Lum (1973)
Harold Sexton (1972)
Fred I. Gilbert, Jr. (1972)
Hau N. Vu (1973)
Winfred Y. Lee, Commissioner
H. E. Crawford (Hawaii) (1971)
Verne Adams (Hawaii) (1973)
Clyde Ishii (Kauai) (1972)
Clifford F. Moran (Maui) (1973)

Indigent Medical Care Committee

Richard T. Mamiya, Chairman (1973)
Daniel Bessesen (1973) Resigned
Richard K. Blaisdell (1972)
Walter W. Y. Chang (1973)
Louise Childs (1972)
Raymond deHay (1973)
Mary A. Glover (1972)
James Mertz (1972)
Shigeo Natori (1971)
Ralph R. Sachs (1972) Resigned
Calvin C. J. Sia (1971)
Herbert Wong (1973)
Verne L. Adams (Hawaii) (1971)
P. M. Cockett (Kauai) (1972)
Kenneth A. Haling (Maui) (1973)
John R. Watson, Commissioner

Japanese Speakers Bureau

Toshihiko Kawasugi, Chairman (1972)
Noboru Akagi (1972)
Keiichi Goshi (1973)
Mitsuo Hattori (1972)
Harry H. Nakata (1971)
Hideo Namiki (1973)
Shigeo Natori (1972)
Richard Sakimoto (1972)
Emiko Sakurai (1972)
Fumiyo Sugimoto (1972)
Perry Sumida (1973)
Naomitsu Tajima (1971)
John Takamura (1973)
Kazushi Tanaka (1972)
Yoshiki Ushiyama (1972)
Tatsuo Watanabe (1972) Resigned
Tsuyoshi Yamashita (1972)
Henry N. Yokoyama, Vice Chairman (1973)
Cesar De Jesus, Commissioner
Theo. T. Oto (Hawaii) (1971)
Kenneth K. Fujii (Kauai) (1972)
K. Izumi (Maui) (1973)

Legislative Committee

Richard K. C. Lee, Chairman (1973)
Richard K. Blaisdell (1972)
Donald F. B. Char (1972)
Clarence F. Chang (1972)
Philip T. Chu (1973) Deceased
Richard W. D. Dang (1971)
Cesar B. De Jesus (1972)
David Eith (1973)
Gerald Faulkner (1973)
H. Wm. Goebert, Jr. (1971)
Calvin C. M. Kam (1973)
Roy Kuboyama (1972)
P. Howard Liljestrand (1971)
Bal Raj Mehta (1973)
James L. Mertz (1972)
Rodman B. Miller (1972) Resigned
George H. Mills (1973)
Clifford Mirikitani (1972)
Kenneth W. Momeyer (1972)
Robert Noyes (1973) Resigned
Noboru Oishi (1973)
F. J. Pinkerton (1971)
Walter B. Quisenberry (1972)
George F. Schnack (1971)
Theodore T. Tomita (1972)
Herbert Uemura (1973)
Sau Ki Wong (1973)
Clarence A. Wyatt, Jr. (1972)
George Goto, Commissioner
John Zelko (Hawaii) (1972)
Kenneth K. Fujii (Kauai) (1973)
Clayton A. Johnson (Maui) (1973)
Clifford F. Moran (Maui) (1971)
Charles Stewart (Maui) (1973)
Sakae Uehara (Maui) (1973)

Maternal & Perinatal Mortality Study Committee

Ann B. Catts, Chairman (1973)
Maurio P. Bautista (1973)
Murray Berger (1972)
Louise Childs (1972)
George Goto (1971)
Ralph Hale (1973) Resigned
Martha Lou Hefley (1973)
William H. Hindle (1973)

Francis M. Ikezaki (1971)
John A. Krieger (1971)
Corazon A. Manayan (1971)
Paul F. McCallin (1971)
Bunzo Nakagawa (1973)
Herbert M. Nakata (1972)
John M. Ohtani (1972)
Arthur T. Osako (1971)
Richard Y. Sakimoto (1971)
Millard S. L. Seto (1972)
Walton K. T. Shim (1971)
Calvin C. J. Sia, Commissioner
Roy Smith (1973)
Francis H. Soon (1973)
Theodore K. L. Tseu (1973)
Hau N. Vu (1971)
Sorrell H. Waxman (1971)
James T. S. Wong (1973)
Paul J. Caldwell (Hawaii) (1971)
Clyde H. Ishii (Kauai) (1971)
H. Lawrence Allred (Maui) (1971)

Medical Care Plans

Benjamin C. K. Tom, Chairman (1972)
Claude Caver (1973)
William W. L. Dang (1973)
Raymond M. deHay (1972)
Masato Hasegawa (1973)
Gail G. L. Li (1971)
Wallace W. S. Loui (1972)
Paul McCallin (1972)
Robert K. Mookini, Jr. (1971)
Shigeo Natori (1972)
Robert W. Peyton (1971)
Ralph R. Sachs (1972) Resigned
Theodore T. Tomita (1972)
John Watson, Commissioner
Samuel R. Wallis (Kauai) (1971)
William E. Iaconetti (Maui) (1972)

Medical Education Committee

Max G. Botticelli, Chairman (1973)
Sharon J. Bintliff (1973)
Richard Blaisdell (1973)
Donald Char (1973)
David A. Fisher (1973) Resigned
Raymond H. Fujikami (1973)
Norman Goldstein (1971) Resigned
Lawrence H. Gordon (1972)
Ralph Hale (1973)
John A. Krieger (1972)
Ivar Larsen (1973)
T. K. Lin (1972)
Richard Mamiya (1971)
Robert A. Nordyke (1972)
Robert W. Noyes (1972) Resigned
Harry C. Shirkey (1972)
Ramon Sy (1973)
Patrick J. Walsh (1972)
Sorrell H. Waxman (1972)
Winfred Y. Lee, Commissioner
George Bracher (Hawaii) (1973)
E. H. Fell (Hawaii) (1973)
Frank Tabrah (Hawaii) (1973)
M. A. Brennecke (Kauai) (1971)
P. M. Cockett (Kauai) (1973)
Clifford Moran (Maui) (1973)
John F. Morris (Maui) (1972)

Medicine and Religion Committee

Francis H. Soon, Chairman (1973)
Noni Brar Koch (1973)
Ralph Hale (1973)
Peter Larm (1973)
Pershing Lo (1973)
Wilfred T. Ohta (1971)
Robert W. Peyton (1972)
Goonzo Yamashita (1973)
Cesar De Jesus, Commissioner
DeWitt H. Smith (Hawaii) (1973)
Eugene Rames (Kauai) (1971)
J. Mark B. Sowers (Maui) (1972)

Mental Health Committee

George F. Schnack, Chairman (1971)
Edward F. Furukawa (1971)
Michael F. Hase (1973)
Maurice Howell (1972)
Francis M. Ikezaki (1972)
Pershing Lo (1973)
K. Y. Lum (1973)
William H. Sage (1972)
Leigh Sakamaki (1973)
Maurice Silver (1973)
Robert Weiner (1972)
Ronald Yamaoka (1973)
Calvin C. J. Sia, Commissioner
Jose Romero (Maui) (1973)
J. Kendall Wallis (Maui) (1973)
Joan J. Takeuchi (Kauai) (1972)

National Legislation Committee

L. Q. Pang, Chairman (1973)
Donald F. B. Char (1972)
Cesar B. De Jesus (1971)
David Eith (1973)
Bernard W. D. Fong (1972)
Richard K. C. Lee (1971)
Wilbur S. Lummis, Vice Chairman (1972)
Don E. Poulson (1971)
J. I. F. Reppun (1973)
Theodore T. Tomita (1972)
George Goto, Commissioner
John Zelko (Hawaii) (1973)
Clyde H. Ishii (Kauai) (1971)
Clifford Moran (Maui) (1972)

Negotiating Committee

Chew Mung Lum, Chairman (1973)
Grover H. Batten (1971)
B. Allen Richardson (1973)
Theodore T. Tomita (1972)
John Watson, Commissioner
Paul Caldwell (Hawaii) (1973)
Walter S. L. Loo (Hawaii) (1972)
Samuel Wallis (Kauai) (1973)
J. M. B. Sowers (Maui) (1971)

News Media Committee

Henry N. Yokoyama, Chairman (1973)
John Ronald Brown (1972)
Claude V. Caver (1972)
Rowlin L. Lichter (1971)
Bal Raj Mehta (1972)
Alexander Roth (1971)
Stephen H. Tenby (1972)
Cesar De Jesus, Commissioner
Keith Nesting (Hawaii) (1972)
Robert Emrick (Kauai) (1973)
Clayton Johnson (Maui) (1973)
Clyde Rossberg (Maui) (1973)

Nominating Committee

William W. L. Dang, Chairman
Max Botticelli
Albert Chun-Hoon
Reginald Ho
George Mills
James A. Mitchel (Hawaii)
Yonemichi Miyashiro (Kauai)
Sakae Uehara (Maui)

Operation Paeific Committee

George Suzuki, Chairman (1972)
L. Clagett Beck (1971)
Edward W. Boone (1972)
Anna Marie Brault (1972)
John R. Brown (1973)
Claude V. Caver (1973)
Frederick A. Dodge (1972)
Unoji Goto (1971)
William H. Gulledge (1973)
William J. Holmes (1972)
William P. G. Jones (1973)
Paul McCallin (1972)
Robert W. Peyton (1973)
Thomas H. Richert (1973)
Nathan Shklov (1973)
Francis M. Terada (1972)
Benjamin C. K. Tom (1972)
Garton Wall (1973)
Cesar De Jesus, Commissioner
Paul J. Caldwell (Hawaii) (1971)
Katok Chuang (Kauai) (1972)

Pharmaey Committee

Daniel D. Palmer, Chairman (1971)
Ralph B. Berry (1971)
Elmars M. Bitte (1973)
John F. Chalmers (1973)
Windsor Cutting (1973)
Frederick S. F. Lee (1972)
Harry C. Shirkey (1972) Resigned
George Goto, Commissioner
Reginald S. Carvalho (Hawaii) (1972)
Joan Takeuchi (Kauai) (1973)
J. M. B. Sowers (Maui) (1971)

Publications Committee

Meryl Haber, Chairman (1972)
Samuel D. Allison (1973)
Harry L. Arnold, Jr., ex officio
Thomas Frissell, Treasurer
Norman Goldstein (1973)
Richard T. Mamiya (1971)
Frank McDowell (1973)
K. S. Tom (1972)
Winfred Y. Lee, Commissioner
R. P. Henderson (Hawaii) (1972)
Kenneth K. Fujii (Kauai) (1973)
Frank A. St. Sure (Maui) (1971)

Public Relations Committee

Rowlin L. Lichter, Chairman (1972)
John Ronald Brown (1972)
Claude V. Caver (1972)
Robert C. H. Chung (1971)
David A. Fisher (1973) Resigned
Robert Flowers (1973)
Fred I. Gilbert, Jr. (1971)
Forrest J. Pinkerton (1972)
O. D. Pinkerton (1971) Resigned
Thomas Richert (1973)
Henry N. Yokoyama (1973)
Cesar B. De Jesus, Commissioner
William N. Bergin (Hawaii) (1971)
Charles Custer (Kauai) (1972)
J. Mark B. Sowers (Maui) (1973)

Quackery Committee

William H. Sage, Chairman (1973)
Robert C. Bell (1973)
Frederick A. Dodge (1971)
David Eith (1973)
Carl E. Johnsen, Jr. (1971)
Hideo Oshiro (1971)
Kleona Rigney (1972)
Harry C. Shirkey (1972)
Francis H. Soon (1971)
Walter S. Yokoyama (1972)
Cesar De Jesus, Commissioner
Walter Batchelder (Hawaii) (1973)
Yonemichi Miyashiro (Kauai) (1971)
Clifford Moran (Maui) (1972)

Radiation Committee

George W. Henry, Chairman (1973)
Carl Boyer (1973)
Thomas C. Brown (1972)
Hans W. Graumann (1971)
Virgil Jobe (1973)
Philip Lee (1973)
Grover Liese (1973)
William J. Natoli (1973)
Robert A. Nordyke (1971)
Robert G. Rigler (1972)
J. C. Wang (1972)
Calvin C. J. Sia, Commissioner
George Bracher (Hawaii) (1973)
A. C. Johnston (Kauai) (1971)
Donald Dietrich (Maui) (1973)

School Health Committee

Roy Kuboyama, Chairman (1972)
Robert D. Bart (1973)
Donald F. B. Char (1972)
Louise S. Childs (1973) Resigned
David T. Eith (1972)
Mary A. Glover (1972)
Michael F. Hase (1971)
Felix J. Lafferty (1973)
Donald C. Marshall (1971) (Resigned)
Donald Maruyama (1973)
Norman Nakamura (1972)
John H. Peyton (1972)
Leigh Sakamaki (1972)
Roy Smith (1973)
Stephen H. Tenby (1973)
Raymond J. C. Wong (1971)
Ronald Yamaoka (1973)
Ann Barbara Ho Yee (1972)
Calvin C. J. Sia, Commissioner
Ruth Oda (Hawaii) (1972)
P. M. Cockett (Kauai) (1973)
James F. Fleming (Maui) (1971)

Scientific Program Committee

Arnold Siemsen, Chairman (1972)
L. Clagett Beck (1973)
Kenneth Gardner (1973)
Mitsuo Hattori (1972)
Reginald Ho (1972)
Richard K. B. Ho (1971)
Glenn Kokame (1972)
John Krieger (1972)
Wilbur S. Lummis (1972)
Richard T. Mamiya (1972)
Roger Ogata (1973)
Noboru Oishi (1972)
Bucnaventura E. Realica (1971)
Millard Seto (1972)
Walton K. T. Shim (1972)
R. Varian Sloan, ex-officio
K. S. Tom (1971)
Herbert S. Uemura, Vice Chairman (1972)
Sorrell Waxman (1972)
Edward Y. Yamada (1972)
Coolidge S. Wakai, Commissioner
Frank Tabrah (Hawaii) (1973)
Eugene Rames (Kauai) (1971)
K. B. McCollum (Maui) (1972) Resigned

Television-Radio Committee

Theodore K. L. Tseu, Chairman (1971)
Claude V. Caver (1971)
Clifford B. G. Chang (1973)
Walter W. Y. Chang (1973)
Ralph Cloward (1973)
Ellis Devereux (1972)
Robert Flowers (1973)
Rowlin L. Lichter (1972)
Bal Raj Mehta (1973)
William F. Moore, Jr. (1973)
Jared Morris (1972) Resigned
Kazuo Teruya (1971)
Thomas Teruya (1972)
Henry N. Yokoyama (1972)
Walter K. W. Young (1972)
Cesar B. De Jesus, Commissioner
Tokuso Taniguchi (Hawaii) (1972)
Ruth E. Oda (Hawaii) (1972)
W. W. Goodhue (Kauai) (1973)
J. M. B. Sowers (Maui) (1971)
Milton Howell (Maui) (1972)

Water Safety Committee

Michael M. Okihiro, Chairman (1973)
Elmars M. Bitte (1973)
Roger B. Brault (1971)
Ralph Hale (1973)
Mitsuo Hattori (1973)
Virgil Jobe ((1973)
Wayne Limber (1973)
Harold Sexton (1973)
Francis Terada (1972)
Calvin C. J. Sia, Commissioner
Pete T. Okumoto (Hawaii) (1971)
Peter Kim (Kauai) (1972)

Woman's Auxiliary Committee

Edward L. Chesne, Chairman (1973)
Philip M. Corboy (1973)
Victor Hay-Roe (1973)
Harold G. Lawson (1971)
Jerome L. Tucker (1972)
Cesar DeJesus, Commissioner
Shizuto Mizuire (Hawaii) (1972)
Sakae Uehara (Maui) (1971)

Workmen's Compensation Committee

Theodore T. Tomita, Chairman (1972)
Francis T. C. Au (1973)
Edward L. Chesne (1973)
William W. L. Dang (1972)
Raymond deHay (1973)
Raymond C. Dusendschon (1971)
Lawrence H. Gordon (1972)
Kiyoshi Inouye (1971)
Calvin C. M. Kam (1972)
Rowlin Lichter (1973)
Herbert K. N. Luke (1972)
Robert K. Mookini, Jr. (1971)
Maurice Nicholson (1972)
Roger Ogata (1973)
Noboru Oishi (1972)
L. Q. Pang (1973)
Garton Wall (1973)
John Watson, Commissioner
James A. Mitchel (Hawaii) (1973)
W. W. Goodhue (Kauai) (1971)
J. Alfred Burden (Maui) (1973)

Ad Hoc Committee to Coordinate AMA Clinical Session in Honolulu

George H. Mills, Chairman
Harry L. Arnold, Jr.
A. S. Hartwell
William E. Iaconetti (Maui)
Homer Izumi
David Wm. Jones (Hawaii)
Yonemichi Miyashiro (Kauai)
Richard D. Moore
F. J. Pinkerton
R. Varian Sloan
Theodore T. Tomita

Ad Hoc Committee to Develop HMA Position on Drug Abuse

Charles W. Stewart, Jr., (Maui) Chairman
Donald F. B. Char
Frederick A. Dodge
Fred Goff
Stanley Kobashigawa
Felix J. Lafferty
B. R. Mehta
Kleona Rigney
Leigh Sakamaki
Harry Shirkey
Roy G. Smith
John R. Stephenson (Deceased)
Calvin C. J. Sia, Commissioner
Walter E. Batchelder (Hawaii)
DeWitt H. Smith (Hawaii)
Albert C. Johnston (Kauai)
Dorothy N. La Fon (Maui)
Reginald C. Carvalho (Hawaii)
Jose Romero (Maui)

Ad Hoc on Malpractice Insurance

Alan Pavel, Chairman
Herbert Y. H. Chinn
Thomas Frissell
Elmer Johnson
John J. Lowrey
Frank McDowell

AWARDS

Medical Journalism Awards

1st place, Professional Division—Murry Engle, Star-Bulletin
2nd place, Professional Division—Robyn Rickard, Advertiser
Co-winners, Educational Division — Gladys S. Liu, Sydney A. Burrell
A. H. Robins Award—Neal E. Winn, M.D.
Special Recognition for Newspaper Series on Death and Dying—A. A. Smyser, Editor Star-Bulletin

Sportsmen's Awards

TENNIS

Yutaka K. Yoshida and Leabert R. Fernandez—Doubles Champions

GOLF

President's Trophy—Albert K. T. Ho, M.D.
G. McD. Van Poole Perpetual Trophy—Albert K. T. Ho, M.D.
Louis A. Gaspar Perpetual Trophy—Samuel L. Yee, M.D.
Low-Gross (Waialae Club)
Low-Gross (Oahu Club)—James G. Harrison, Jr., M.D.
Low-Net (Oahu Club)—William W. L. Dang, M.D.
Winthrop Trophy—R. Varian Sloan, M.D.
George H. Mills Perpetual Trophy for Pharmaceutical Representatives—Bud Bentley

PROCEEDINGS OF THE HOUSE OF DELEGATES

115th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the president, John J. Lowrey, at 1:00 P.M., April 27, 1971, in the Moorea Room of the Ilikai Hotel.

Present were (officers) John J. Lowrey, George H. Mills, Herbert Y. H. Chinn, R. Varian Sloan, and Thomas P. Frissell; (county presidents) J. Mark B. Sowers; (councilors) Grover H. Batten, William W. L. Dang, Yonemichi Miyashiro, and William E. Iaconetti; (Honolulu delegates) Douglas B. Bell II, Max Botticelli, Ann B. Catts, Frederick A. Dodge, George M. Ewing, Bernard W. D. Fong, William Goebert, Jr., George Goto, Reginald C. S. Ho, Richard K. B. Ho, Gordon Liu, Michael M. Okihiro, Niall M. Scully, Calvin C. J. Sia, Benjamin C. K. Tom, Frederick Warshauer, Philip H. F. Watt, Walter H. K. Watt, and Livingston M. F. Wong; (Maui delegate) John F. Morris; (past presidents) Samuel D. Allison, Harry L. Arnold, Jr., F. J. Pinkerton, Theodore T. Tomita, and Samuel Yee.

Honolulu president Thomas P. Frissell, asked that the following alternate delegates be seated to complete Honolulu County's delegation: James G. Bennett for Albert Chun-Hoon, H. H. Chun for William W. L. Dang, Cesar B. DeJesus for Thomas P. Frissell, Arthur K. Wong for Alfred D. Morris, Winfred Y. K. Chang for Robert Rose, Willard Miyahira for Arturo Salcedo, and William Sage for Henry H. L. Yim.

Alternate delegates from Hawaii County were seated as follows: DeWitt H. Smith for James E. Mitchell, Timothy D. Woo for Haruto Okada, and R. P. Wipperman for Reginald S. Carvalho.

Maui president, Mark Sowers, asked that alternate delegate A. Y. Wong be seated for Edward B. Underwood.

There were no delegates from Kauai present.

The minutes of the May 5-9, 1970, meeting were approved as published.

Dr. Harry L. Arnold, Jr. was appointed parliamentarian. Dr. William Sage and Dr. Livingston Wong were appointed sergeants-at-arms.

The reports of the President, Secretary, and Treasurer as well as those of Hawaii, Honolulu, Kauai, and Maui County Societies were in the Delegates' Handbook and were referred as indicated. The reports of the standing and special committees were referred to the reference committees as previously announced. Resolutions 2 and 3 were referred to the Reference Committee on Insurance and Medical Services; Resolutions 1 and 4 to the Reference Committee on Miscellaneous Business; and Resolutions 5, 6, and 7 to the Reference Committee on Parliamentary Affairs.

Dr. Willard Miyahira was asked to serve on the Reference Committee on Public Health to replace Dr. Gail G. L. Li. Dr. Robert Rose was replaced by Dr. Winfred Chang on the Reference Committee on Insurance and Medical Services and Dr. Yonemichi Miyashiro replaced Dr. Peter Kim on the Reference Committee on Parliamentary Affairs.

It was voted to reconvene the House of Delegates on April 29, 1971, at 1:00 P.M.

* * *

The Reference Committees were in session April 27, beginning at 1:30 P.M.

* * *

The second session of the House of Delegates was called to order on Thursday, April 29, 1971, at 1:00 P.M. The secretary called the roll.

Honolulu delegates Frederick A. Dodge, Bernard W. D. Fong, and Gail G. L. Li were absent the second day. Dr. Peter Kim was seated as the delegate from Kauai. Past presidents Harry L. Arnold, Jr., O. D. Pinkerton, and Samuel Yee were present for the second session.

Mrs. G. Prentiss Lee, President of the Woman's Auxiliary to the AMA, was introduced and asked to address the House.

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience consisting of Dr. Walter Quisenberry, Director of the Department of Health; interested guest members of his staff; and various committee chairmen. It received testimony on the reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AUTOMOTIVE SAFETY

With the Medical Advisory Board for Driver Licensing a (Governor-appointed board) now functioning, the Automotive Safety Committee has had no specific goals this past year and has not been very active. However, automotive safety is still such an important aspect in which the medical societies can be of service to the public, that the committee should be continued.

RECOMMENDATION: The committee should continue along the same lines as in the past, with emphasis being placed on studying and trying to do something about the major cause of fatal accidents, the drinking driver.

TRUETT BENNETT, M.D.

Automotive Safety

Your Reference Committee first considered the Automotive Safety Committee report. No one appeared to discuss this report. Your Committee recommends approval of this report and its recommendation. In addition, we recommend that the committee should study and try to do something about auto safety regulations enforcement, as had been recommended last year. Your Committee was disappointed that this had not been reported. Your Committee also recommends that the inspection and regulations of noxious automobile emissions be studied by the committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER

The Cancer Committee engaged in the following activities during the past year:

1. Approved the encouragement of each of the major hospitals in the State to establish an oncology unit. Such units will provide trained personnel and equipment to provide specialized care to the cancer patients. Patient morale may also improve.

2. Established details of the Coordinated Cancer Program as follows:

a. Coordinated monthly regional tumor conferences to be rotated among the various hospitals in the State. Initial participants will be St. Francis, Queen's and Kuakini Hospitals.

b. Oncology workshops in the various hospitals especially in cooperation with the Cooperative Chemotherapy Program of Hawaii.

c. Continue close working relationship of the various hospital registries, Cooperative Chemotherapy Program and the Hawaii Tumor Registry.

d. Publication of cancer statistics, conference and lecture schedules and other cancer news of interest in the HMA Newsletter and HMA JOURNAL. Publication of a cancer newsletter in cooperation with the American Cancer Society will be explored.

3. The committee had continued good working relationship with other agencies such as the Cancer Commission and the American Cancer Society with periodic reports by the liaison members. We did not, however, maintain liaison with RMP as such a member was not appointed.

The Cancer Commission report is being submitted separately. There is no budgetary request.

RECOMMENDATIONS:

1. Encouragement of the major hospitals in the State to establish oncology units.
2. The Coordinated Cancer Program be implemented.
3. Continue close liaison with the Cancer Commission and American Cancer Society and re-establish liaison with RMP-Hawaii.

The chairman of the committee would like to take this opportunity to officially thank the members of the committee and the secretaries for their interest and cooperation.

THOMAS K. L. LAU, M.D.

Cancer

Your Reference Committee then considered the Cancer Committee report. Your Committee recommends amendment of the first recommendation to read "Encouragement be extended to include all local community hospitals in the State to update and establish oncology units." Your Committee further recommends that each local community hospital be encouraged to appoint an individual trained in cancer therapy, responsible for setting up a standing committee on cancer to help guide the cancer program, to implement a Tumor Registry, and to hold a cancer oriented meeting at least once a month. Your Committee approved the last two recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER COMMISSION

The Hawaii Tumor Registry, with the aid of personnel supported by the American Cancer Society, Hawaii Division, has made an intensive effort to assist in reducing the backlog of cases in several Honolulu hospitals. In addition, the registries on several neighbor islands have been brought up-to-date. The mechanics to find and register cases in hospital outpatient, chemotherapy and radiotherapy departments have been established. In all, almost double the number of cases accessioned yearly heretofore will have been handled this year.

The Registry is taking part in planning for the expansion of a variety of demographic studies under the aegis of the National Cancer Institute and has contributed to several local studies as well. With funding from a major program of this type, a maximum effort to design and implement an electronic data processing system will be the primary initial concern of the Registry, to be followed by the preparation of a variety of listings and reports to all the participating institutions and their medical staffs. The Cancer Commission expresses its appreciation to the American Cancer Society, the Hawaii State Department of Health and to the HMA for its support of the activities of the Registry.

DRAKE W. WILL, M.D.

Cancer Commission

Your Reference Committee then considered the report of the Cancer Commission and accepts this important report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CHRONIC ILLNESS AND AGING

The committee held four meetings the past year. It was recommended that Dr. Kleona Rigney be appointed as representative of this committee to the Commission on Aging in the absence of Dr. Sachs.

There was considerable discussion throughout the year concerning Intermediate Care Facilities. Dr. Shepard reported on the problems involved in intermediate care facilities. The committee feels that none of these problems are subject to any easy solution, but this committee should become a resource for helping the State insure the best use of the State's available institutions.

One of the chief concerns of this committee is the physical and mental fitness of senior citizens. We have followed up on the Senior Citizen Well-Health Program and Dr. Rigney has reported to the committee on this. Suggestions from this committee were made to Dr. Rigney regarding speakers for Senior Citizen Well-Health Program throughout 1971.

This committee feels that it should continue to encourage future health programs for health screening and senior citizen centers.

RECOMMENDATIONS: (1) Training programs should be encouraged to provide ancillary personnel for geriatrics services. (2) Encourage future health programs for senior citizen centers and health screening. (3) Look into the possibility of a symposium at the end of 1971 or the beginning of 1972, relating to geriatrics health care or some other specific area relating to geriatrics. This program would be on a statewide basis.

L. CLAGETT BECK, M.D.

Chronic Illness & Aging

Your Reference Committee next discussed the report of the Chronic Illness & Aging Committee. Your Committee recommends that the first recommendation be accepted. We also recommend that the following be added to the end of the second recommendation: "... in addition to their annual physical examination by their personal physician." We recommend the third recommendation be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNICABLE DISEASE & IMMUNIZATION, VENEREAL DISEASE AND TUBERCULOSIS

The importance of good communications between the Department of Health and the Hawaii Medical Association was emphasized in the control of the streptococcal infection outbreak at Kawananakoa School in October, 1970. The Communicable Disease Committee recommended the continued cooperation between the HMA and the Department of Health in future similar incidents.

Because of the rising rate of V.D. among the younger age group, recommendations were made to the Department of Education that a competent educator be assigned to develop a venereal disease program in the public schools.

RECOMMENDATION: Encourage the physicians to immunize Hawaii's teen-age group against rubella following the guide lines of the American Public Health Association. No budget is requested.

L. T. CHUN, M.D.

Communicable Disease and Immunization, Venereal Disease, and Tuberculosis

Your Reference Committee next considered the report of the Communicable Disease Committee and ac-

cepted the recommendation but was disappointed that the committee did not study shigellosis or hepatitis, which were significant health problems within the current year. It further recommends and encourages this committee and individual physicians work closely with the Department of Health in trying to afford emergency treatment for communicable disease epidemics and, also, to explore better means for preventive care for these epidemics.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DIABETES

Standardization of Diabetes Detection Procedure: Both testing and data collecting methods have been reviewed by the committee in an attempt to standardize the methods used by the County Societies. This would make data analysis more accurate and lead to better understanding of the diabetic population in Hawaii.

The Dextrostik method using the Reflectance Meter has been reported to be very accurate, and this method will be encouraged by the committee because of low cost factor, ease of operation, and accuracy.

The Beckman Glucose Analyzer has been found to be extremely accurate but the cost, maintenance, and transporting problems were factors against it.

Data collection and recording methods have been evaluated by the Chronic Disease Branch of the State Department of Health, and their method will be adopted by all County Societies, if accepted this fall.

Community Participation: The Oahu Lions Club has offered to participate in a year round detection program under the guidance of this committee. Their interest stems from the high incidence of retinopathy among diabetics.

The Hawaii Lay Diabetes Society has offered to help with County detection program. As in the past, they have covered the expenses of the Diabetes Summer Camp for children.

Diabetes Summer Camp for Children: The Third Annual Camp was again held at Camp Erdman under the direction of this committee, which supplied the camp physicians. The cooperative efforts of the Hawaii Diabetic Association, the State Department of Health, and the Lay Diabetic Society resulted in a successful camp for diabetic children—ages 8 to 12. Instructions by the staff covered practical aspects of diet at each meal, self administration of insulin, and ways to avoid complications. The main emphasis was to develop a sense of self sufficiency and to maintain normal association between the diabetic and non-diabetic children campers.

Diabetes Screening: Results of the screening test performed by the various counties are tabulated below. In addition to detection of new diabetics, it served as a means of public education.

	TOTAL SCREENED	NO. POSITIVE DEXTROSTIK	NO. POSITIVE AUTO ANALYZER
Hawaii County	3,752	140	72
Honolulu County	6,006	335	160
Maui County	1,682	57	36
Kauai County	1,936	Using the Unopette and auto analyzer:	225

Honolulu County used the Reflectance meter in part of the survey and Kauai County used the auto analyzer with the unopette collecting method.

RECOMMENDATIONS: (1) That the HMA encourage the County Societies to use a standardized method of conducting diabetes detection programs. (2) That the committee continue to encourage community participation in detection and educational programs. (3) That the committee continue to investigate more effective means of conducting detection programs. (4) That continued educational programs for medical and paramedical groups be encouraged.

WILLARD MIYAHIRA, M.D.

Diabetes

Your Reference Committee next discussed the report of the Diabetes Committee. Your Reference Committee accepts this report and all recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DISASTER

The Disaster Committee of the Hawaii Medical Association has been inactive because of the absence of some easy practical way for all county chairmen to meet. Since this committee is on a State level as opposed to the county committees, the only chance it has to function at all is for the county chairmen to meet with the State chairman. Without this, there can be no coordination of county efforts in disaster planning. Letter communication is ineffectual, and obviously transportation funding for county chairmen to meet in Honolulu is too costly. As an alternative, telephone calls will have to do. Without any better means of communication with the county chairmen than now exists, letter mail, this committee is doomed to continued footdragging and ofttimes token efforts in the name of disaster planning. Attached is a budget to cover the costs of telephone conferences with neighbor islands. It is hoped that this will be looked on with favor.

BUDGET—HMA DISASTER COMMITTEE

July 1, 1971 to December 31, 1971 = $44.10

This is based on three (3) person-to-person telephone calls to each of the three (3) county chairmen for an average of twelve (12) minutes per call. Total number of calls is then nine (9). Cost of each call is $4.90 ($4.45 plus $0.45 tax).

January 1, 1972 to December 31, 1972 = $88.20

This is based on total of eighteen (18) telephone calls. Other computations remain the same.

MILLARD SETO, M.D.

Disaster

Your Reference Committee next considered the report of the Disaster Committee. The Committee noted the small budget request and recommends slight increases to $50.00 for the July 1, 1971 to December 31, 1971 period and $100.00 for the 1972 calendar year. Your Committee also recommends that the Disaster Committee study the "Proposed Concepts For Systems Planning For Disaster Preparedness" as submitted by Dr. Ereida Reichert. Your Committee also recommends that closer liaison should occur between Dr. Reichert of the Department of Health and this committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DRUG ABUSE, AD HOC

In June of 1970 the Ad Hoc Committee on Drug Abuse of the Hawaii Medical Association undertook to investigate in the legislature the possibility of obtaining a mandate for a broad interdisciplinary study of the drug abuse problem throughout the State. The result of these efforts was the establishment by Senate Concurrent Resolution No. 75 of the Hawaii Committee on Drug Abuse under the aegis of the Ad Hoc Committee and composed of knowledgeable professional and lay people in the community. The efforts of the Ad Hoc Committee per se, following the creation of the Hawaii Committee on Drug Abuse, have been largely limited to

critical medical review of the deliberations of the State Committee and endorsement of its recommendations, which were transmitted to the Legislature in January of this year and the summary of which is appended to this brief report as further evidence of our labors.

Unfortunately, despite the mandate of the previous legislature, the 1971 Legislature chose to shelve our recommendations at least for the time being and did not even report out of committee the bills pertaining to our major recommendation; namely, the creation of a Commission on Dangerous Substances.

At the present time, although disappointed by this setback, the Ad Hoc Committee, now meeting jointly with the Hawaii Committee, is exploring the possibility of working out some of the elements of our proposed program through the Governor's Office. We intend to pursue this approach until the intent of the Executive Department becomes clear. At that time the Ad Hoc Committee on Drug Abuse will make some decision regarding both the continuation of the Hawaii Committee on Drug Abuse and our participation in whatever administrative efforts are deemed worthwhile.

RECOMMENDATION: In view of the foregoing discussion, we would like to strongly recommend the continuation of the Ad Hoc Committee on Drug Abuse for the following year.

CHARLES W. STEWART, JR., M.D.

SYNOPSIS OF THE REPORT OF THE HAWAII COMMITTEE ON DRUG ABUSE

I. GENERAL THEME OF REPORT

The report was the result of six months of intensive study by a representative committee. Input was received from a variety of community groups on a Statewide basis. These groups included: youth, police, physicians, legislators, community groups, users, etc. The document presents a framework within which a coordinated and concerted impact can be made on the problem of drug abuse in our State.

It should be noted that the success of the approach suggested is dependent upon (1) the appointment of the proper individuals to the suggested Commission, (2) the cooperation of agencies and individuals involved, (3) the setting aside of vested interests and various egocentric patterns to deal honestly with the problem, and (4) the willingness of agencies and groups to receive, without prejudgments, a variety of ideas and suggestions from all segments of the population involved in the problem.

II. THE HAWAII STATE COMMISSION ON DANGEROUS SUBSTANCE AND ITS COMPONENTS

The Commission is to be a central Statewide coordinating body, directly responsible to the Executive Branch of the State government. It must be broadly representative and composed of members who are knowledgeable and active in the field of drug use and abuse. No one group should dominate the Commission, i.e., physicians, youth, government departments or private agencies.

The Commission would serve primarily as an advisory body and resource to the Legislature, departments and agencies of government, and when appropriate, to private community groups and individuals. It would be responsible for coordination, review and integration of existing programs as well as new programs which develop. It would also have control of special funds which could be utilized to test the efficacy of a variety of program approaches to the problem.

The Commission would be responsible for (1) reviewing and maintaining the list of dangerous substances contained in the Controlled Dangerous Substances Act, gathering and collating information on drug problems in a "drug abuse Registry," (2) Evaluation of programs through establishing criteria, providing means for collecting data and applying data against the criteria as a feedback to those operating the program, (3) Supervision of the Consultation and Referral Service, a program which deals with the areas of toxicology, acute and chronic poisoning, detoxification and treatment assessment, and long-term treatment and rehabilitation, as well as providing consultation for addiction problems and serving as an educational resource.

Another aspect of the Commission's responsibility is in the area of coordination of community programs. A Community Drug Committee is suggested as a mechanism for bringing together all action programs specifically focused on the problem of drug abuse for the purpose of coordination and information-sharing. This group would include both private and public programs being conducted within the military and civilian communities in the State. Types of activities would include examination of program components, ascertaining the scope of available resources and suggesting patterns of cooperation to avoid unnecessary duplication. Committee comments and recommendations would be made to the Hawaii Commission on Dangerous Substances.

The Hawaii State Commission would also have major responsibility in the development and stimulation of a wide variety of experimental, pilot or demonstration projects. Innovation which has the potential for changing patterns of behavior, either on the part of those delivering services or for those using drugs, should be encouraged. It is through the exploration of innovation alternatives to existing activities that meaningful change will occur, resulting in effective amelioration of the problem of drug abuse.

III. FUNDING, STAFFING AND SUPPORT

Effective coordination within the framework suggested in the report can become a reality if funding is provided for staff and the programs suggested. Of primary importance is the provision of adequate funding for staff and operating expenses of the Commission ($75,000). The coordinative effort cannot be effectively directed unless this body is created within the Executive Branch of the State Government.

A funding pool for allocation to demonstration projects ($240,000) is of almost equal importance. It is recognized that there is usually some reluctance to appropriate moneys unless detailed program budgets have been worked out. It must be recognized that new and innovative programs are few at the present time. Many concepts are in the developmental stage and conceivably will be developed into specific programs within the next year. The problem of drug abuse is increasing in Hawaii and will continue to do so unless specific programs are instituted as rapidly as possible. One of the major blocks to program institution is the lack of a funding source which is flexible enough to provide funds when the *program* is ready. The funding cycle in Hawaii is such that the program must usually wait until the *funds* are ready. Delay in the field of drug abuse could prove disastrous.

Other aspects of the coordinated effort recommended by the report, and their amounts are as follows:

Consultation and Referral Service.....	$265,000
Coordination of Existing Agencies (If Hawaii State Commission Administrative Staff Is Not Utilized.....	20,000
Program Evaluation and Research.....	20,000

The total amount requested ($600,000) is 8/100ths of one per cent (.0008) of the total budget that the State government is currently proposing for the whole of Hawaii.

Drug Abuse, Ad Hoc

Your Reference Committee then considered the report from the Ad Hoc Committee on Drug Abuse. It commends the committee for the time and effort spent on this important project. The Committee recommends changing the first recommendation to read: "In view of the foregoing discussion, we would strongly recommend continuation of the Ad Hoc Committee on Drug Abuse

with subsequent conversion to a standing committee." Your Committee further recommends that the study of the problem of alcohol be considered by this Committee. Your Committee recommends that the concept of the Hawaii State Commission on Dangerous Substances and its components be endorsed and legislation to form this Commission be encouraged and passed. Your Committee reaffirms its support of the Drug Abuse report.

ACTION:

It was pointed out that an ad hoc committee can continue to exist as long as neeessary. A motion was made and seeonded to delete the words "with subsequent conversion to a standing eommittee" from Reeommendation No. 1 in the reference committee report. The Chairman moved adoption of this portion of the report. It was adopted.

ENVIRONMENTAL HEALTH

The Environmental Health Committee was chosen from many volunteers, with suggestions from HMA President Dr. Lowrey.

Purposes and objectives defined by the committee as a whole:

1. Physicians should make the public aware that they are concerned in environmental health.
2. The committee should take stands on different issues.
3. The committee should not get involved in the "how to" but should get involved with philosophy and objectives.
4. The committee should influence the direction of its recommendations.
5. The committee should be able to identify and define what is not good in the environment.
6. The committee should concern itself with man and his environment together with a consideration of the technology involved and the implementation to bring about an optimum environmental state.
7. The committee should make value judgments.
8. Since the basis of political power resides in the people, the committee should bring to bear political pressures necessary to accomplish solutions to environmental problems.

The committee met at bi-weekly intervals since formation November, 1970, considering problems and issues of environmental health.

Liaison was kept with environmental groups such as the Conservation Council, Sierra Club, Life of the Land and with the State Department of Health, whose representative sat on the committee.

The committee added representatives ex officio members from the Hawaii Nurses Association, Hawaii Tuberculosis and Respiratory Disease Association, and the Student American Medical Association.

The committee's assistance was requested by the State Department of Health when the local newspapers publicized conditions of pollution in Keehi Lagoon. This resulted in the committee's advice to post the waters of Keehi Lagoon.

Your committee chairman was asked by the chairman of the University of Hawaii Air Pollution Task Force to serve as a medical member. This Task Force produced the recommended ambient air quality standards later endorsed by the HMA Environmental and Legislative Committees.

Two committee members served as panelists at an Air Quality Standards Workshop sponsored by the Hawaii Tuberculosis and Respiratory Disease Association.

The committee reviewed many bills during the Legislative session. Letters of support were written for those bills thought to be beneficial to environmental health. Testimony was offered in support of H.B. 69 in the House Health and Judiciary Committees.

Methods of keeping the public informed on environmental health matters were discussed. A proposal was offered to the Health Department.

Your committee chairman has most recently been asked by Patsy T. Mink, Member of Congress, to assist in refuting alleged "misstatements of facts" in the McAteer Brochure recently released. Time and staff limitations curtailed the scope of the chairman's reply, which essentially *supported* the truth of the statements in the brochure.

Action was taken in support of:

1. Extensive bacteriological testing and monitoring of recreational waters subject to fecal pollution from sewage or surface runoff.
2. Increased funding and staffing for the Department of Health.
3. Adoption of the air quality standards of the University of Hawaii Air Pollution Task Force.
4. Pilot studies to measure heavy metals in our environment.
5. Analysis of solid waste production and disposal.
6. Pesticide research and monitoring of agricultural, industrial, and domestic sources of pesticide residues.
7. Strong population control measures.
8. Early development of non-polluting mass transit systems.

JAMES L. ERICKSON, M.D.

Environmental Health

Your Reference Committee then considered the report of the Environmental Health Committee. Your Committee commends the committee chairman, Dr. James L. Erickson, for his active and extensive work this year and noted with sadness that he plans to leave in July, 1971, as his leadership was well appreciated over the last year in this important problem. Your Committee recommends a strong replacement for committee chairman. Your Committee recommends that the Hawaii Medical Association assist this committee via the news media and public relations committee and recommends that Dr. Erickson meet with the component Medical Association committees and interested societies as soon as feasible to explain the environmental program, to disseminate the committee's findings, and obtain active participation and support so that Legislation will be soon enacted. Your Committee would like to express its disappointment in the lack of Legislative action in these important issues but hopes they will be acted upon in the next legislative session.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEART

The Heart Committee held one meeting this year for the purpose of considering and discussing the following:

1. Requirements for training of ambulance personnel.
2. Obtaining information regarding resuscitation attempts.
3. Statewide cardiopulmonary resuscitation training requirements for physicians.
4. The role of nurses in cardiopulmonary resuscitation.

Heart programs active throughout the State are furnished with volunteer services of physicians, most of whom are represented on the Heart Committee. The programs of the Hawaii Heart Association appear to provide the activity throughout the community. For this reason, it is the feeling of the chairman that the chief function of the HMA Heart Committee is to sanction and support the activities of the Hawaii Heart Association. Although dormant, the HMA Heart Committee should perhaps not become extinct because it provides liaison to other committees of the HMA, such as the Legislative Committee, and continues to be of value.

JOHN F. HANLEY, M.D.

Heart

Your Reference Committee then considered the report of the Heart Committee and recommends that the committee be continued as it provides liaison with other community organizations in their field. There was also some discussion about the establishment of an Emergency Care Committee, which would include other individual catastrophe occurring outside the hospital and specifically include ambulance equipment and emergency personnel training.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MATERNAL & PERINATAL MORTALITY STUDY

The committee met a total of five times during the year. Five perinatal deaths and four maternal deaths were discussed and classified. Two of these cases, both perinatal, were from 1969, the remaining seven deaths occurred in 1970. The functions of the committee were limited for several months because of personnel shortages in the Hawaii State Department of Health. The committee would like to extend special thanks for the cooperation and assistance given to it by the members of Dr. Louise Childs' staff at the Maternal and Child Health Branch.

Although there are twenty-four members assigned to this committee, excluding the neighbor island representatives, an average of less than one-half that number attend the meetings. Lack of interest may be due in part to the fact that most of the unusual or overtly instructive cases have been discussed previously at various hospital conferences and rounds. The question has been raised as to whether this committee should continue to investigate all maternal and perinatal deaths which occur in the State, or limit its discussions to those cases which are not presented at hospital death conferences, and to cases referred to it by physicians or hospitals. A complete discussion of this basic approach to the committee case review needs to be undertaken by a majority of the committee members. It is urged that everyone who agrees to serve on this committee take an active part in directing and achieving its goals.

Although minutes of the Family Planning Council meetings are available to the committee a closer liaison with this Council would be appreciated.

RECOMMENDATIONS: (1) That the HMA representative to the Family Planning Council of Hawaii be a member of the Maternal & Perinatal Mortality Study Committee. (2) That representatives from obstetrics, pediatrics, and general practice, including members from neighbor islands, meet to decide if this committee should continue case investigations, and, if so, set up procedural guidelines which will ensure a better liaison between the committee and the attending physicians and hospitals involved in the cases.

Maternal & Perinatal Mortality Study

Your Reference Committee then considered the report on Maternal and Perinatal Mortality Study Committee. Your Committee recommends acceptance of the report and recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH

During 1970-71 no issues or problems were referred to the committee. Some bills relating to mental health subjects introduced in the Legislature were discussed, and testimony on a bill relating to learning disabled and emotionally disturbed junior and senior high school children was submittted. A bill for the licensure of psychologists was at first vigorously opposed, followed by development in conjunction with the Hawaii Psychiatric Society, Hawaii Psychological Association, and State Department of Regulatory Agencies of changes that would make it highly acceptable, which was then pushed for enactment.

The committee continued projects already underway during the past several years. One of them, insurance coverage for mental health services, should be an ongoing project ad infinitum. By the time of this writing several meetings (two of them jointly with a committee of the Mental Health Association) have been had with Mr. Albert Yuen of HMSA in follow-up of the resolutions adopted by the 1969 House of Delegates regarding third party payment of psychologists and non-psychiatrist physicians for mental health services. As indicated in last year's report, HMSA is considering inclusion of additional such benefits. However, they are finding difficulty in delineating which psychologists may be covered for psychotherapy, have decided against covering psychotherapy as such, out patient psychiatric care will in all likelihood soon be significantly increased, but none will yet be included in individual plans.

The Chairman, as Training Director for continuing education of non-psychiatrist physicians, attended two meetings held by WICHE for training of such directors and for training of teachers in such programs by invitation of WICHE. Expenses for two other meetings on the Mainland for teachers of such programs were partly defrayed by the NIMH grant, currently in its final year. This grant is also aiding in the continued planning for a multidisciplinary project in continuing education for all personnel whose work relates to mental health; the present effort is in developing a grant application to be submitted by the University of Hawaii College of Health Sciences and Social Welfare to NIMH later this spring.

Considerable planning has been done for a June conference to be jointly sponsored with the State of Hawaii Judiciary Department, Family Court, the University of Hawaii, Social Welfare Development and Research Center, and possibly the American Psychiatric Association, Physician Education Project. A week of sessions open to the public by registration will consider aspects of "alienated adolescents" and "the generation gap," and a weekend outside Honolulu will be limited to more intensive study by a limited group of physicians. This will terminate the NIMH grant, at least for a year.

RECOMMENDATIONS: Programs for next year should include (1) continuing effort to increase insurance coverage for mental health services, (2) it is suggested that cooperative effort with the Mental Health Association in this—and selected other areas—may be more effective than working alone (this committee might be patterned after the Legislative Committee which routinely included *ex officio* members from the Health Department, Hospital Association, and Nurses), and (3) it is suggested this committee become involved in the problems of peer review and innovations in delivery of mental health care. (4) Although Hawaii Medical Association will not for awhile have a mental health grant, the Hawaii Academy of General Practice will have access to funds administered by the American Academy of General Practice for continuing education, and this committee should continue or institute cooperative efforts with HAGP and any other organization (such as the College of Health Sciences and Social Welfare, WICHE, RMP, Comprehensive Health Planning, etc.) to assist in continuing education and other efforts in the mental health field.

GEORGE F. SCHNACK, M.D.

Mental Health

Your Reference Committee next considered the report of the Mental Health Committee. Your Committee recommends acceptance of this lengthy report and recommendations, but recommends that in the third

recommendation the material within the parentheses be deleted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RADIATION

One meeting was held during the year to consider the bill being offered in the federal government to mandate the licensing of x-ray technologists. Multiple comments and material was prepared by committee members. The local X-Ray Technology Society has withdrawn their request for a licensure law locally and in view of this and the AMA, American Hospital Association, and American College of Radiology general feeling that licensing of paramedical personnel at this stage is premature, no further action was carried out.

Next year this committee should note the criteria used by the State of California and the results, and how their law has affected the practice of medicine.

GLORGE W. HENRY, M.D.

Radiation

The Reference Committee next considered the Radiation Committee report. Your Committee noted the lack of recommendations and feels this committee should tie in with licensure problems of paramedical personnel, and recommendations should be forthcoming from this committee in the future.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCHOOL HEALTH

The committee met monthly and has participated in the following programs:

Pilot Program to Provide Health Services in Public Schools: The committee, through its recommendations in the Governor's Advisory Committee, made recommendations for the implementation of the program. It actively supported the continuation and enlargement of the program at the 1971 Legislative Seminar.

Sports Medicine Seminar-Workshop: Sports Medicine will conduct a seminar-workshop on "Safety in Sports" on April 30 and May 1, 1971, for team physicians, athletic directors, coaches, and trainers of the schools in Hawaii. The guest speaker is Dr. Frederick L. Behling, sports physician for the Stanford football team.

School Physician: This committee was active in obtaining the services of C. George Murdock, M.D., Hawaii's first school physician in the Department of Health. The committee is supporting many programs proposed by Dr. Murdock.

Other Programs: (1) Dr. Barbara Ann Yee represented the committee on the Department of Education Task Force on the school lunch program. (2) Approved the first aid chart of the Academy of Pediatrics, 1970, for use in public schools. (3) Approved "Diet and Nutrition for Athletes" submitted by the Department of Education. (4) Approved a pilot program submitted by the Department of Health on early detection of scoliosis. (5) Met with administration of Punahou School so that physical examinations will be continued to be given at the student's birthdate instead of during the summer months. (6) Calvin C. J. Sia, M.D., is representing the HMA on the Community Task Force of Special Education. (7) Dr. Michael Hase is representing the committee to the Department of Education Task Force to set up emergency procedures in the time of drug crisis. (8) Approved the revised Form 14 and 15, school physical examination forms submitted by Dr. Murdock.

BUDGET REQUEST:

Representative to the AMA School Physician Seminar	$ 500 (1971)
Representative to the AMA School Physician Seminar	500 (1972)
Total Request	$1,000

RECOMMENDATION: This committee recommends that the HMA endorse and support the concept that school health includes health services, health education and environmental health.

ROY F. KUBOYAMA, M.D.

School Health

Your Reference Committee next considered the School Health Committee report and recommends that the recommendation be accepted but the budget request be deleted. Your Committee agreed that attendance at many of the AMA sponsored seminars is of value but possibly funds could come from other sources. The possibility of multipurpose health forms should continue to be studied.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WATER SAFETY

The Water Safety Committee of the Hawaii Medical Association was re-activated and held three meetings during the past year.

Mr. Kenji Ego of the Fish and Wildlife Service gave us a very thorough and lucid discussion of the shark problem in Hawaii. The shark problem is really not a very great problem for there have only been 25 recorded unprovoked shark attacks over the past 75 years, but for obvious reasons whenever such an attack occurs, it creates a great deal of emotional response. At the present time, the State Department of Land and Natural Resources is asking the Legislature for more money to continue its shark control and research activities. A proposal has been put forth in the present Legislature to put a bounty on sharks, but we agreed with Mr. Ego that this would not be a worthwhile project and we have presented written testimony to the appropriate legislative committee against the proposal for shark bounty.

We also had testimony from a commercial scuba diver and instructor about various aspects of water safety and scuba diving. There are approximately three dozen drowning deaths per year in the Hawaiian Islands and although accurate figures are not available, it does seem that the incidence of scuba deaths may be increasing. Some discussion was had as to the feasibility of licensing the diving shops who dispense the compressed air for the scuba divers, but at the present time it is felt that the best way to prevent scuba deaths would be in the way of education rather than licensing.

Finally, we heard a very nice talk from Lt. James Mitchell from the Pearl Harbor decompression chamber who gave us facts and figures on the incidences and types of diving accidents that they handle. Lt. Mitchell was asked to write up a paper which it is hoped will be printed in the HAWAII MEDICAL JOURNAL about their experiences at the decompression chamber.

We have no budget requests.

RECOMMENDATIONS: (1) That the Water Safety Committee be kept active in view of the continuing rather steady number of accidental drownings which occur in this State. (2) That the Water Safety Committee look into the matter of water pollution which seems to be a very popular problem at the present time and which we have not gone into the past year.

MICHAEL M. OKIHIRO, M.D.

Water Safety

Your Reference Committee then considered the Water Safety Committee report and noted the committee's increased activity over last year. The first recommendation was approved. Your Committee feels the second recommendation should be deleted as this will be studied by the Environmental Health Committee. Your Committee recommends that the Water Safety Committee study the problem of drownings especially in scuba diving and tourist water safety. Your Committee also recommends that proper swimming education be encouraged.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON PUBLIC HEALTH

There are many active committees under my commission and I wish to commend the chairman and the members of the committees for their active participation. The Ad Hoc Committee on Drug Abuse spent countless hours in preparing their final report on drug abuse to the Legislature and it is hoped that some form of this report will become legislation. The Environmental Health and School Health Committees have held regular monthly meetings. It is my strong recommendation that other committees set up regular meetings in the future to continue the momentum in meeting the various issues that challenge medicine today. I would also like to challenge those committees that have had only one or two meetings to seriously consider their function and to consider whether the committee should be dissolved or placed on an Ad Hoc basis. I feel very strongly that some of the committees may duplicate efforts of community public health committees or agencies. However, the HMA must have some area for communication both for the physician and the community representatives.

I would heartily recommend the acceptance of the recommendations of the various committees.

CALVIN C. J. SIA, M.D.

Report of the Commission on Public Health

Your Reference Committee then considered the report of the Commission on Public Health and recommends that the report be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ACTION:

The Chairman moved adoption of this report as a whole as amended. It was adopted.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and gave careful consideration to the matters referred to it. The committee is pleased to make the following report:

BUREAU OF RESEARCH AND PLANNING

The Bureau had a late start in 1970-71; the chairman was elected by the Council in August and the first meeting was held on October 5. Subsequent meetings were held on October 27, November 10, December 1, January 19, February 11, and March 23. Attendance, in general, has been poor, with less than half a dozen of the 19 member committee attending regularly. Three members of the committee—Lichter, Hay-Roe, and Sachs—have dropped out. Dr. Alexander Anderson's (or RMP) helpful presence by invitation is gratefully acknowledged.

Chapter VIII, Section 13(c) of the HMA Bylaws, states: "The committee (Bureau) shall be directly responsible to the Council and House of Delegates and shall carry on whatever work it is assigned or which it deems necessary to keep abreast of the times and prepare the Association to meet future challenges. It shall suggest or develop projects. . . ."

With this broad mandate in mind, the chairman outlined his interpretation in an agenda for the year (October 6, 1970): (1) Continuation of the evaluation of the quality of medical care in Hawaii (HMA-Payne Study) both outside of and in hospitals; (2) the question of a four-year U of H medical school; (3) how to keep the costs of medical care reasonable; (4) peer review mechanisms both in and out of hospitals; (5) long-range planning for more extended care facilities; (6) promotion of medical education of the lay public in the interests of greater self-care, and (7) review the internal structure of the HMA, particularly the development of membership and participation, benefits in exchange for responsibilities.

The Bureau has been active as a "think tank" for the Council. Its continuing agenda includes: (1) The HMA-Payne Study which is progressing and already bearing fruit; (2) monitoring and furthering the establishment of a four-year medical school; (3) Peer Review of non-hospital medical care (a matter being considered by the U. S. Congress); (4) HMA cooperation with the UH School of Public Health in a project proposed by Dr. Robert Worth on "The Monitoring of Ambulatory Care Through Data Linkage" and Dr. Robert Mytinger's barely-alive project to evaluate the need for type and number of hospital beds; (5) last but not least, the Bureau has started, and should complete within the coming year, "Principles of Health Care," a foundational concept that HMA can hopefully adopt.

There are no recommendations.

J. I. F. REPPUN, M.D.

Bureau of Research and Planning

Your Reference Committee first considered the report of the Bureau of Research and Planning. The Committee noted the extensive work of the Bureau and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BYLAWS & PARLIAMENTARY

The committee held no meetings during the fiscal year.

HARRY L. ARNOLD, JR., M.D.

Bylaws and Parliamentary

Your Reference Committee next considered the report of the Bylaws and Parliamentary Committee. It has not been necessary for the Bylaws Committee to meet during the past year but it was noted that major responsibilities have been assigned to the Bylaws Committee for the coming year.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FINANCE

The Committee met several times during the year and acted upon the following matters:

Common Fund Operation: The Common Fund was created as a result of the merger of the Hawaii Medical Association and the Honolulu County Medical Society staffs. Included are three separate types of funds—(1) common inseparable expenditures, primarily involving payroll and rent; (2) common expenditures that are accountable to each organization such as supplies, postage, telephone, etc.; and (3) separate general fund operations for each organization which are not to be comingled nor disbursed under common heading. Each organization (HMA and HCMS) have separate operations that are nonrelated to each other; e.g., HMA has a Physicians' Benevolent Fund, the publication of the HAWAII MEDICAL JOURNAL and the Roster. The HCMS has the Hawaii Foundation for Medical Care, the Bureau of Medical Economics, and the Medical Plaza, Inc. The operations of these programs are not included in the common fund budget. The non-common expenses will be paid from the respective association's general fund. The Committee recommended to the Council and was subsequently approved by the Council at its September 18, 1970 meeting that the president and treasurer of each organization assume the responsibility of the Executive Board of the combined operation; that checks for budgeted items require two signatures, one of which may be the Executive Director's; and that checks for nonbudgeted items require the signature of one officer from each organization.

Office Equipment: To increase staff effciency, the Committee approved the purchase of a new addressograph machine to replace the old model. This approval was subsequently approved by the Council of the HMA and the Board of Governors of the HCMS.

Renovation of Present Offices: As a result of the HMA-HCMS staff merger, the present offices had to be renovated in order to bring both staffs under one roof. Approval by the HMA Council and the HCMS Board of Governors was given for this undertaking and that the cost not exceed $500.00.

Retirement Fund: The Committee recommended to the Council and to the Board of Governors that the retirement fund for the combined staff be merged. It was approved and both governing bodies directed that Peat, Marwick & Mitchell be named the actuary consultant for the combined retirement program.

Investment Program: The House of Delegates approved a recommendation that HMA pursue a vigorous investment policy. A subcommittee was appointed by the Chairman and was instructed to investigate possible investments. The Committee was reassured by Council to continue in the investigation of income-producing projects. The subcommittee has explored the possibilities of investing in (1) real estate, and (2) tax exempt bonds. The Committee generally agreed that common stocks were not a reasonable investment for the Association. Real estate was considered with the idea of purchasing income property, possibly through the mechanism of Medical Plaza, Inc., because of the tax liabilities that might be generated. The subcommittee voted to explore the possibility of a real estate investment program in conjunction with all county medical societies and the Bureau of Medical Economics. Letters were written to all county medical society presidents outlining the plan and asking for their consideration relative to this matter.

Oahu Country Club Transferable Membership: The $1500 transferable membership to Oahu Country Club paid by the HMA for Miss Lee McCaslin has not been received. The last letter written to Miss McCaslin regarding this matter was written on August 3, 1970, and no word has been received since that time.

Life Insurance Program: The Committee recommended to the Council, which was subsequently approved, that the HMA provide a group life insurance program for its staff and that it be paid for out of the common fund. It should be noted that the HCMS staff has long had a group life insurance program.

HMA Budget: The Chairman recommended to the President that at the time of the House of Delegates meeting that the Treasurer be allowed to give a short presentation in regard to the budget before the Reference Committees go into session. The purpose of the presentation is to make each Reference Committee aware of the recommendations made by the Council at its meeting on April 9 at which time all committee budget requests were considered.

Site Subcommittee: During the year, the subcommittee has been exploring various sites for the HMA-HCMS and Bureau of Medical Economics future Headquarters. The subcommittee continues to investigate all avenues and no definite report is available at this time.

Remuneration for HMA Officers: At the last House of Delegates meeting it was mandated that the Committee explore some compensation methods for the President and other officers of the HMA. Information was received from the AMA relative to what other states are doing in this area. No definite recommendations have been made.

Auditors: At the 1970 House of Delegates meeting the Treasurer's Report contained a recommendation to continue with Leong and Leong as the Auditors of HMA, and which was approved by the House. Subsequently, discussions have been held with Mr. Leong and he concurs that with the combined program it is best that only one auditor be used. The Committee recommended and received approval from the Council that Alexander Grant & Company be named the auditing firm for HMA and HCMS effective July 1, 1970.

In view of the audit requirements for evaluating the changeover to the common fund of HMA-HCMS, it was reported that two audits are required—one in July, 1971, and one in January, 1972. The July audit will be primarily a procedural audit to assess the mechanism through which the common fund is being controlled in connection with the two organizations. A certified audit will be requested for January, 1972.

The Committee recommended and received approval from the Council that the HMA fiscal year be changed to a calendar year.

Physicians' Benevolent Fund: The Committee investigated the status of the Physicians' Benevolent Fund and requested that Leong and Leong apply for a ruling from the IRS with respect to its tax exempt status under Section 501(c)(6). Without committee approval, Leong and Leong engaged its attorneys, the firm of Wooddell, Mukai and Wirtz to look into this matter. A copy of a letter, written by Mr. Mukai of the above-mentioned firm, to the IRS was received and subsequently a reply from IRS was received. The HMA Executive Director was asked to consult with HMA's Legal Counsel to clarify this reply before any decisions are made by the Committee. The status of the fund is, at the present time, status quo and no recommendations are forthcoming at this time.

RECOMMENDATIONS: (1) That the Committee continue to pursue an income-producing program. (2) That the Committee continue to explore various sites for the HMA-HCMS and BME future headquarters. (3) That the Committee continue to study reports on the remuneration for HMA officers. (4) That the fiscal year be changed to a calendar year.

THOMAS P. FRISSELL, M.D.

Finance

Your Reference Committee next considered the report of the Finance Committee and carefully reviewed the recommendations. Your Committee recommends approval of all recommendations of the Finance Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE

The Legislative Committee began meeting regularly in October 1970 and spent several meetings discussing the recruitment of a legislative counsel. Mr. Ben F. Kaito was appointed legislative counsel in late December and was assigned to work primarily on the malpractice insurance bills. The legislative counsel's report contains a summary of the action taken in this area and of this writing it appears that one of the measures, HB 637 relating to discovery of proceedings and records of review committees of medical societies and hospitals, will be enacted.

The committee met with Senator Mason Altiery and Representative Richard Garcia, chairmen of the Senate Health Committee and House Public Health Committee respectively, both of whom are new members of the Legislature. The committee discussed items of interest to the Association and offered the services of the HMA to the Legislature in matters relating to health.

There were 1635 bills introduced in the House of which 181 related to health. In the Senate, 1315 bills were introduced of which 136 pertained to health. Bills were assigned to various members of the committee and other interested physicians of the Association. The following members of the HMA participated actively in drafting position statements and appearing at legislative committee hearings:

Drug Abuse—Drs. Charles W. Stewart and Frederick A. Dodge
Environmental Health—Dr. James L. Erickson
Penal Code and Mental Health — Dr. George F. Schnack
Physician's Assistant, Health Manpower, and CHEC —Drs. H. H. Chun, Cesar B. DeJesus, H. W. Goebert, Jr., and Robert A. Nordyke
Family Planning, Minor's Consent—Dr. George Goto
Four-year Medical School—Drs. J. J. Lowrey and Max Botticelli
Hospital (Franchising, Act 97 Commission, etc.)— Drs. P. H. Liljestrand, Sakae Uehara, John Morris, and Richard K. C. Lee
Automotive Safety—Dr. Truett V. Bennett
School Health—Dr. Roy Kuboyama
Pharmacy—Drs. Daniel D. Palmer and John F. Chalmers
Malpractice Insurance — Drs. John J. Lowrey and Alan Pavel
Workmen's Compensation—Dr. Theodore T. Tomita

Physicians also appeared at hearings on child abuse, qualifications for the Director of Health, immunity in blood and tissue transplants, rubella vaccination, DSS budget, custodians of medical records, residency requirements for physicians, correctional diagnostic centers, centers for learning disabilities, etc.

Listed below is the budget request for the committee for the next one and one-half years. There has been no increase in the Legislative Counsel's fee for the past seven years. It is also intended to utilize the services of the counsel very early in the year during the formation of the legislative program rather than only during the legislative session. The Legislative Committee did not utilize the entertainment fund during the past year. However, it is the recommendation of the counsel that the committee actively meet with legislators prior to the session and therefore we have recommended that the entertainment fund again be included in the budget.

BUDGET REQUEST:

	1971 (6 mons.)	1972 (12 mos.)
Legislative Counsel	$	$6,500.00
Entertainment	500.00	1.000.00
Today's Health	150.00	150.00
Miscellaneous	100.00	100.00
	$750.00	$7,750.00

RECOMMENDATIONS: (1) That the budget of the Legislative Committee be approved as submitted. (2) That the chairman and members of the Legislative Committee be selected as early as possible in order to begin meeting with legislators and formation of the legislative program can be accomplished prior to the opening of the legislature. (3) That the services of the legislative secretary, Mrs. Becky Kendro, be acknowledged and that she continue to serve in this capacity. (4) That the physicians who have been actively involved with legislative activities continue to represent the Association so that their expertise in the various fields will become recognized. This is especially important in light of the fact that those measures not enacted this session will be carried over for the 1972 session. (5) That the invaluable services of Mr. Ben F. Kaito be acknowledged and that his contract be extended for another year.

RICHARD K. C. LEE, M.D.

Legislative

The report of the Legislative Committee was considered next by your Reference Committee. A full and complete discussion was held. Your Committee recommends approval of all recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NATIONAL LEGISLATION

Because last year was an election year and a filibuster followed by an extended session of Congress, at which time nothing much was brought up regarding health measures, only one meeting of this committee was held. This concerned the Professional Standards Review Organization (PSRO) amendment sponsored by Senator Wallace F. Bennett (R–Utah). There was rather bitter opposition to this amendment by the AMA. These objections were (1) that it would not insure the review of a physician's service by his peers, (2) it would require pre-admission approval before hospitalization for the elective procedures or long-term treatment, (3) it would create national norms for care and treatment, (4) it would set penalty provisions which would subvert the intent of peer review, (5) it would require federal ownership of data acquired by the PSRO, (6) it would require physician review of services to extend beyond those services for which he has responsibility and control, and (7) it would provide for demonstration projects under which the PSRO assumes the role of risk underwriter and payment revering agent.

Following the AMA's testimony, several of these provisions reportedly were altered by the Senate Finance Committee. The language of PSRO, as tentatively approved by the committee, is not known at this time. Therefore, no action was taken pending receipt of the amendments. To this date, we have not received any data about this.

L. Q. PANG, M.D.

National Legislation

Your Reference Committee next considered the report of the National Legislation Committee and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE

In October, 1970, it became obvious that a serious situation in regard to professional liability insurance had developed in Hawaii. Without going into detail, the situation that we faced was that most of the established

carriers had either pulled out of the field entirely or were refusing to accept new applications, particularly in the higher risk levels.

It was the purpose of the committee to explore the reasons for the vanishing market and to attempt to develop an outlet for the coverage.

A number of conferences were held with the Insurance Commissioner and with representatives of the insurance industry. The Department of Health, Education and Welfare tried to assist but were unable to accomplish anything.

The program contemplated by the AMA in connection with the Continental Assurance Company did not develop into a satisfactory solution.

The proposal for a local capital stock insurance company was not acceptable to the committee.

The only market available to us did not open up without a very great increase in rates. A local company offered coverage at approximately double the basic rates plus a series of surcharges that sometimes increased the rate by as much as 600%.

In November, the Insurance Commissioner approved rates that were double the prior levels.

In January, 1971, we entered into negotiations with the Argonaut Company.

In the meantime, the Association of Clinics had developed a reciprocal type program underwritten by a mainland combination of insurance companies for the limits above the local acceptance. The committee evaluated this program carefully as it was offered to the physicians statewide. The committee could not endorse the plan, primarily because of the limited number of exposures, and because the written contracts and agreements were not available. Meetings were held with the attorneys of the program and in general the attorneys agreed with the committee decision.

The agreement with the Argonaut Insurance Company was concluded to the satisfaction of the committee and the coverage offered to all physicians in the State. The rates were set at manual "A" rates with an experiment review at twenty months and annually thereafter. Full disclosure was guaranteed. The HMA would review all cases of doubtful insurability and make recommendations to the company. The committee would review all claims and make recommendations as to settlement or contest.

On April 1, 1971, the committee was advised that the reciprocal arrangement of the clinic groups was being discontinued. We are pleased to report that the Argonaut Insurance Company agreed to pick up the physicians that had been covered under that program retroactively with certain reservations as to "known claims." To date this pickup has gone smoothly.

The committee is happy to report that coverage is available to the doctors of Hawai. It will be necessary that the committee continue to function in the operation of the program to assure the continuance on a rational basis.

ALAN PAVEL, M.D.

Ad Hoc Committee on Professional Liability Insurance

Your Reference Committee next considered the report of the Professional Liability Insurance Committee and wishes to commend the chairman and committee members for their extensive work in solving some of the problems surrounding professional liability insurance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON LEGISLATION

The Commission on Legislation consists of the Legislative, National Legislation, Pharmacy and the Ad Hoc Committee on Community Health Services.

The Sixth State Legislature was still in session when this report was submitted, but I am pleased to report that the Legislative Committee under the able leadership of its chairman, Dr. Richard K. C. Lee, was effectively functioning on behalf of the Association at the State Legislature. Much of the credit of the smooth operation of this committee must be given to its able and conscientious secretary, Mrs. Becky Kendro, who has efficiently kept the committee apprised of the rapid and sometimes unexpected developments in the State Legislature. Our new legislative counsel, Mr. Ben F. Kaito, has measured up to all expectations required of a counsel. His services to the Association have been invaluable and are hereby acknowledged.

The deliberations and actions taken by the committee of the commission are summarized in the report of each committee except for the Ad Hoc Committee on Community Health Services which has not met since its creation by the House of Delegates in 1969.

RECOMMENDATION: (1) That the House of Delegates disband the Ad Hoc Committee on Community Health Services and allow the new president to appoint another Ad Hoc Committee if there is a need for such a committee.

GEORGE GOTO, M.D.

Commission on Legislation

Your Reference Committee next considered the report of the Commission on Legislation. Your Committee recommends that the Recommendation be changed as follows: Delete that portion of the sentence beginning with "allow the new president to appoint another ad hoc committee if there is a need for such a committee." It was noted that the president already has the power to appoint ad hoc committees and thus it is not necessary to include this statement in the recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT

This past year has been the most challenging, varied, and meeting filled year of my life. It has been a privilege and education to serve you. The work of your organization is done by your committees, officers, councillors, commissioners, and staff. Whatever has been accomplished is due to their devoted labors. The President's job as I saw it was to try and give coordination, purpose, encouragement and stimulation to the many diverse activities of the organization. Through all our activities I would like to see presented to the community a cooperative profession dedicated to the better health of the people we serve. Medicine is changing. People are changing and we must change with them.

The year's activities are covered in your committee reports.

RECOMMENDATIONS: (1) that because the HMA-HCMS staffs are merged, committees of both organizations be combined for more efficient use of doctors' time and to seek ways for the combined staffs to better serve neighbor island county societies; (2) that there be continued closer working relationship through staff and committees with the legislature, Department of Social Services, and other government and community organizations, and that there be more staff participation with these organizations; (3) that the Bylaws be rewritten to reflect changes in the committee structure; (4) that Peer Review be implemented throughout the State; (5) that we encourage membership of medical students, interns, and residents in the HMA by amendments to the constitution and bylaws; (6) that HMA continue studies on quality of care; (7) that HMA cooperate with and guide health planning efforts in the community when the projects are properly initiated.

My thanks to all doctors who have served the HMA this year and particularly to our HMA staff for their cooperative efforts and attitude during this transition period.

A special vote of thanks also to the members of the Woman's Auxiliary who have so generously given their time to help in the activities of the Association.

JOHN J. LOWREY, M.D.

President's Report

Your Reference Committee next considered the report of the President. Your Committee recommends approval of Recommendations Nos. 1, 2, 3, 4, 6, and 7 and further recommends that Recommendation No. 5 be changed by adding "regarding the dues" after the last word in the sentence. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SECRETARY

The total active membership of the Association as of December 31, 1970, was 789, a decrease of 7 compared to December 31, 1969 which was 796. During the previous years, the figures were as follows: 1968—768; 1967—758. The inactive members, reported only through Honolulu county, numbered 21, the same as the previous year. Of the 789 active members, 75 were granted dues waiver, an increase of five over the previous calendar year.

The total number of unlimited licenses issued to physicians to practice medicine in Hawaii as of December 31, 1970, was 1601, an increase of 69. The preceding years this increase amounted to 93 in 1969, 63 in 1968, 71 in 1967, 112 in 1966, 53 in 1965, 34 in 1964, and 62 in 1963. There were 540 physicians licensed to practice in Hawaii who did not reside in the State, an increase of 40 over the previous year.

The first temporary and limited licenses were issued in 1965. These licenses are valid for 18 months only, except that interns and residents are required to renew annually. Physicians in government employ are able to renew their temporary and limited licenses indefinitely as long as they remain employed by the government. In the calendar year 1966 a total of 120 temporary and limited licenses were issued. In 1967 the total number decreased to 117, went up to 129 in 1968, and 98 for 1969. The total for 1970 was 187, broken down as follows:

Government	28
Under direction of	77
Intern	42
Resident	36
Emergency	3
Shortage	1

Eight members died in 1970: Kwan Heen Ho, Robert Miyamoto, Richard Sia, Lester Kashiwa, Philip Chu, Chinami Hasegawa, John Stephenson, and Zenko Matayoshi.

Unaffiliated physicians were reported by the counties as follows: Hawaii (not reported), Honolulu 213, Kauai 6, and Maui 7.

By counties, the active membership was made up as follows as of December 31, 1970:

COUNTY	ACTIVE DUES PAYING	ACTIVE DUES WAIVED	TOTAL
Hawaii	48	6	54
Honolulu	599	64	663
Kauai	22	1	23
Maui	45	4	49
	714	75	789

Since the last annual meeting there have been five Council meetings. These were held on July 24, September 18, December 11, January 25, and April 9.

At the July 24 meeting, the Council voted to thank Dr. Rodney West for representing the HMA at the Fourth National Congress on the Socio-Economics of Health Care. Correspondence from Dr. Beverly C. Payne was reviewed regarding the hospital seminars planned for February, 1971. The President reported to the Council on the committee structure and subsequently was asked to form a committee on Environmental Health and an Ad Hoc Committee on Malpractice Insurance. It was noted that the HCMS accepts medical students for membership and their dues are waived.

The Finance Committee recommended that a Common Fund Operation of HMA and HCMS be established and it was voted that the Common Fund Operation be approved and that nonseparable items be on a 50-50 basis which is to be reviewed after one year's experience. The Council approved the request of the Publications Committee to increase the local advertising rates for the HAWAII MEDICAL JOURNAL by 50 per cent. It was also voted that an editorial assistant be hired for all HMA publications with a salary range between $600 and $750. A contingency fund of $500 for the HMA Editor was also approved. It was reported that the annual meeting will be held April 27–May 1 at the Ilikai Hotel. An appropriation not to exceed $500 was approved for the Japanese Speaker's Bureau to purchase visual aids for their programs. The formation of the Health Careers Council was discussed and it was suggested that a policy statement be developed to cover the relationship of the HMA and formation of new community councils. The Secretary was instructed to invite Dr. Roger Egeberg, Assistant Secretary of Health and Scientific Affairs of HEW to meet with the officers and representatives of HMA to discuss the DSS program; and copies of the letter to be sent to the AMA, Governor Burns, Hawaii Congressmen, Mr. Among of DSS, the Ombudsman, Speaker of the House and President of the Senate, and Dr. Richardson of HEW. Bids for the publication of the Relative Value Studies were reviewed and it was voted to accept the lowest bid submitted. The Council approved a retainer fee of $1,200 from HMA to be combined with the $1,800 from HCMS for the legal counsel. The Woman's Auxiliary offered their assistance in implementing HMA projects. Dr. Lowrey reported to the Council on a meeting held with HMSA. Dr. Iaconetti discussed some problems on Maui and it was suggested that representatives of the Foundation for Medical Care visit Maui to discuss the program there. The HAMPAC Board was elected by the Council. Members of the Bureau of Research and Planning and Finance Committee were appointed. The AMA Delegate reported on the June AMA Convention and is hopeful that Hawaii will be selected as the convention site for 1975. The purchase of an addressograph machine was approved. The Council went into executive session and approved that Mr. H. Tom Thorson be given a bonus of $100 per month and that his salary be paid by the Common Fund on a 50-50 basis.

At the September 18 meeting the Council reviewed correspondence from Dr. Beverly C. Payne outlining the plans for the hospital seminars and recommending a seminar on office care for the HMA. The Council asked Dr. Payne to submit a progress report to the Council prior to any commitment on the seminars. The Council also voted to ask Dr. Payne to include a representative from the neighbor islands in one of the four hospital seminars. It was also voted to inform Dr. Payne that the HMA would like to have a seminar on office care. A study to evaluate the quality and acceptability of non-physician managed/physician supervised clinics for chronic diseases being undertaken by Dr. Fred Gilbert of the Straub Medical Research Institute was approved. The Council reviewed the SAMA budget and voted to appropriate $200 for SAMA Hawaii. The Finance Committee recommended that the president and treasurer of HMA and HCMS assume the responsibility of the Ex-

ecutive Board of the combined operation; that checks for budgeted items require two signatures, one of which may be the Executive Director's; and that checks for non-budgeted items require the signature of one officer from each organization; that Peat, Marwick & Mitchell be named the actuary consultant for the combined retirement program; that Alexander Grant and Company be named the auditing firm for HMA and HCMS effective July 1, 1970.

The Commissioner on Education and Scientific Research recommended that the Hospital Committee continue to function following a revision of their present functions so that it may hopefully become a meeting ground for physicians and hospitals in interhospital relations relative to HMA. It was also voted to refer to the Bylaws Committee that the existing AMA-ERF Committee be named the Scientific Research Committee and that new functions be established. The Council did not take action and recommended an in depth study by the Medical Education Committee of the alleged problems of the Hawaii Medical Library. The Council endorsed the concept of a study to evaluate the multiphasic screening operation for chronic diseases by the Straub Clinic Research Institute. The Council denied a request to send a delegate to the AMA National Congress on Health Manpower but noted that the HMA will pay the per diem of a physician who is in the area at the time and attends the meetings of significant importance to HMA. The RMP Hawaii Dietetic Association Project was endorsed. The Council also endorsed the first aid chart of the Academy of Pediatrics for the Department of Education School Health Complexes. It was reported that the membership has been surveyed for members interested in serving on the Environmental Health Committee and Community Health Services Committee. The Council adopted principles for the Community Health Services Committee. Dr. Iaconetti reported on negotiations with the Foundation for Medical Care on Maui. The Malpractice Insurance situation was discussed. A report on the meeting with Dr. Egeberg was discussed. A letter to HMSA regarding specialty fees was circulated and approved. Dr. Lowrey reported on the School of Public Health project noting he had recommended that the HMA become involved in the development of projects rather than being asked for help after the projects are completed. Dr. Mills and Mr. Thorson will attend the AMA Clinical Convention in Boston and will promote Hawaii for the 1975 Clinical Session. It was voted to inform the AMA that a management training course be extended to qualified individuals of the state medical associations rather than limiting it to retiring state presidents.

At the December 11, 1970 meeting the Council voted to approve the assignment of $1,000 from the Medical Education Committee's budget to be used for the HMA's Study on the Quality of Personal Medical Care hospital seminars. The Executive Director was asked to pursue meetings with representatives of HMSA regarding their role and their plans as the fiscal intermediary for the Department of Social Services. The School Health Committee's request to sponsor a workshop on sports medicine was approved. It was voted to approve the cost of one meeting room for the medical students' participation and one booth for the HMA's participation in the Careers Day Program. The Public Relations Committee was advised to tabulate and summarize its Opinion Survey and recommend to the Council relative to what they plan to do with the results. It was voted to merge the HCMS and HMA retirement plans. The Finance Committee was requested to explore a real estate investment program. A policy statement on the formation of Councils was approved. It was voted that Dr. John J. Lowrey fulfill a three-year term as HMA's representative to the Executive Committee of RMP. The Council directed the Executive Director to write a letter to Dr. Paul Sanazaro expressing the HMA's concern regarding the proposal submitted by Dr. Edward O'Rourke, Dean of the School of Public Health. It was reported to the Council that Hawaii was selected as the site for the 1975 AMA Clinical Session.

At a special Council meeting on January 25, Dr. Paul J. Sanazaro and members of his Site Committee discussed the purpose of their visit relative to the process and methodology for the proposed Hawaii Research and Development Program for Improved Health Services. It was voted that an addenda be circulated relative to the change in price of the HRVS—HMA members receive the first copy free and all subsequent copies at $10.00 each. All non-HMA members will be charged $10.00 per copy.

At the February 12 meeting, the Council went on record endorsing the Makana Foundation. It voted to support the development of a four-year medical school at the University of Hawaii, and to support the concept of using community hospitals as teaching hospitals. The theme "Pathology as it Relates to Clinical Practice" for the 1972 Annual Meeting was approved. A position statement related to generic drugs was approved. The Council voted to endorse the Report of the Hawaii Committee on Drug Abuse, and to commend the Hawaii Committee on Drug Abuse for their comprehensive study. They also wrote letters to the Governor, President of the Senate, and the Speaker of the House indicating the endorsement of HMA. The Commission on Public Health was given approval to investigate with the Superintendent of the Department of Education the assignment of an educator to develop a total program in venereal disease. The Commission on Public Health was also directed to develop a statement relative to improved movement of patients from acute hospitals to Extended Care Facilities. The Diabetes Committee was given approval to (1) use the Beckman Glucose Analyzer for diabetes screening, (2) sponsor a Diabetes Seminar which is to be subsidized by organizations other than the HMA, and (3) accept the Lions Club request to help support diabetes screening programs. The Council voted to approve recommendations (1) that school physical examinations for Punahou, Iolani and the Department of Education be established on the birthday month, (2) that support of the School Health Services complex be continued, and (3) that the Department of Education's SHES program on Health Education be endorsed. The Council also approved that a letter be directed to the Director of the Department of Health and the Department of Transportation relative to the sewage pollution problem and the inadequacy of sanitary facilities at the Ala Wai Yacht Harbor. It was voted to direct a letter to U. S. Congress Senator Wallace F. Bennett advising him of HMA's attitude on PSRO; i.e., that all peer review committees be under the auspices of the medical association, that a pilot program should not be underwritten at the physicians' expense, that it is against the idea of physicians being involved in any way in matters other than its own professional problems, and that it does not feel that peer review will solve the cost of Medicare and Medicaid. The Council developed a statement relative to its attitude toward the proposal of the School of Public Health. The Council voted to approve that the HMA proceed immediately with final negotiations for a malpractice insurance plan proposed by the Argonaut Insurance Company. The Executive Director was directed to request the AMA to send its management consultants to Hawaii to study the HMA and HCMS committee structure.

At the April 9 meeting, the Council reviewed all committee budget requests being submitted to the House of Delegates for approval. The Council also considered special reports and requests being submitted to the House of Delegates for approval.

The 1972 Annual Meeting dates of the HMA are from May 7-13 at the new Waikiki Sheraton meeting hall.

RECOMMENDATION: That the Council be granted permission to change the sites and dates of the annual meetings if unforeseen events develop to make the change advisable.

R. VARIAN SLOAN, M.D.

Secretary's Report

Your Reference Committee next considered the report of the Secretary. A full and complete discussion was

held. Your Committee recommends approval of the Recommendation and the report as a whole.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TREASURER

The House of Delegates, in 1970, adopted a budget that was out of balance by about $25,000.00. Through the cooperation of the various committees, it appears that we will finish the year without running up a large deficit. This is in spite of a number of special projects such as the publication of the 1970 RVS, the intensive work of the ad hoc Drug Abuse Committee, the costly hearings of the Workmen's Compensation program, the Beverly Payne Study, etc.

I would recommend that the House of Delegates give careful study to the financial capabilities of the association and review the programs in which we are engaged to establish priorities.

The status of the several funds administered by the Association is reflected in the accompanying balance sheets and operating statements. Please review them carefully.

The development of the Common Fund with participation by the HMA and the HCMS has been implemented and is working. We will not have a full year's experience with this until fall and it is not possible at this time to evaluate the full impact of this fund on our operating procedures. The contributions that HMA will make to this fund are reflected in the proposed budget item by item. You will find an interim statement of the operations of the fund attached.

The Council recommended that the HMA change its fiscal year to the calendar year. This action if approved by the House of Delegates will simplify the overall accounting procedures and reduce the audit cost. The two different accounting years of the two organizations with both of them participating in a common fund makes it almost impossible to establish proper control and audit reporting.

With this change it is necessary that we have an interim budget period from July 1, 1971, to December 31, 1971, and then a full year budget period from January 1, 1972, through December 31, 1972. This means that the six months budget for the last half of 1971 will reflect a substantial operating deficit, because most of our income for the year is received during the first half of the year.

Special programs of the HMA that operate under separate budgets are as follows.

1. The HAWAII MEDICAL JOURNAL is reflected in the overall budget with total figures. The detail is on a separate listing. The JOURNAL, in common with other journals, has had a problem of revenue. Advertising, particularly pharmaceuticals, has been declining for the last several years. New sources of advertising revenue are being explored. The JOURNAL has a small deficit but some savings will be realized.
2. Annual Meeting operations indicate a favorable ratio of costs to revenue. This will no doubt continue as a trend in the future. Registrations from the mainland and collateral activities such as the archery hunt can be expanded. The use of the University Service has been of tremendous help in the planning and operation of the Annual Meeting.
3. Roster activity did not take place in 1970. We do expect to publish a roster for 1971. It is hoped to cover the full cost through advertising revenue.

BUDGET ESTIMATE FOR PERIOD: 7/1/71 TO 12/31/71 AND 1/1/72 TO 12/31/72 AS ADOPTED

Re: General Fund Operation

NAME OF ACCOUNT	ACTUAL 12-mos. period to 6/30/70	BUDGET 1969-1970 to 6/30/70	BUDGET 6-mos. period 7/1/71-12/71	BUDGET for 1972 1/72-12/72
INCOME				
Membership Dues	100,632.50	98,520.00	2,000.00	103,000.00
JOURNAL	23,996.78	30,350.00	10,750.00	30,600.00
Annual Meeting	24,297.50	21,000.00	5,500.00	23,800.00
Annual Roster	4,161.25	10,200.00	680.00	10,300.00
Interest Earned	3,287.25	3,400.00	2,000.00	3,200.00
Miscellaneous	1,589.08	1,000.00	600.00	1,200.00
TOTAL INCOME	157,964.36	164,470.00	21,530.00	172,100.00
EXPENSES				
Salaries	44,952.74	46,500.00	27,000.00	54,000.00
Accounting & Auditing	2,845.00	2,800.00	1,400.00	3,000.00
Auto Allowance & Expenses	920.00	1,200.00	300.00	600.00
Council Expenses	1,169.64	980.00	600.00	1,200.00
Donation	20.00	20.00	225.00	100.00
HAMPAC	200.00	200.00	200.00	200.00
Dues & Subscriptions	970.42	950.00	450.00	900.00
Insurance & Bond	1,503.17	1,600.00	750.00	1,500.00
Library Contribution	100.00	100.00	100.00	100.00
Legal Counsel		1,500.00	780.00	1,560.00
Meeting Expenses	4,387.83	4,000.00	2,000.00	4,300.00
Miscellaneous	225.92	300.00	100.00	300.00
Postage	2,965.88	2,530.00	1,500.00	3,000.00
President's Contingency Fund	646.74	1,000.00	600.00	700.00
Rent	6,834.60	4,950.00	3,780.00	7,560.00
Repairs & Maintenance	223.72	300.00	300.00	300.00
Retirement Plan & Expenses	5,708.37	5,330.00	300.00	4,000.00
Stationery, Printing & Supplies	2,987.15	3,000.00	1,500.00	3,000.00
Special Authorized Expenses	2,706.09	2,500.00	500.00	1,000.00
Taxes—Payroll	2,428.89	2,600.00	1,400.00	3,000.00
Telephone & Telegram	1,970.86	2,000.00	1,000.00	2,000.00
Travel—General	6,443.55	7,700.00	3,000.00	7,000.00
Travel—Committee			1,000.00	2,000.00
Woman's Auxiliary	4,257.50	4,200.00	150.00	4,200.00
Committee Expenses	14,635.41	22,075.00	10,730.00	24,585.00
JOURNAL Expenses	25,062.72	30,280.00	14,718.00	31,386.00
Annual Meeting Expenses	14,489.79	18,060.00	100.00	18,165.00
Roster Expenses	10,241.84	10,000.00	1,500.00	11,606.00
Depreciation (Furniture & Fixtures)	1,192.81	600.00	600.00	600.00
TOTAL EXPENSES	160,090.64	177,275.00	76,583.00	191,862.00
DECREASE IN FUND	(2,126.28)	(12,805.00)	(55,053.00)	(19,762.00)

4. The Physicians Benevolent Fund has about $35,000 in it. The detail is included with the rest of the statements. Some thought has been given to this fund by the Finance Committee and legal opinion has been obtained in regard to the ultimate disposition of the money. At present the funds are deposited separately in three savings accounts.
5. HMA-HCMS Common Fund, used to handle the financial activities of the joint operation of the two organizations is still in the throes of evaluation. The items listed in the reporting of the fund are segregated from the rest of the operating statement. As a result the reflection of budget to operations becomes somewhat academic. The methodology of our approach to this mechanism has been reviewed by the auditor and has been approved by them.
6. Employees retirement fund is reported. The retirement plans of HMA and HCMS are being merged with necessary adjustments being worked out by the actuary and attorney. A copy of the Trustee's report is in the file for review.

In summary, this has been a year of change. Not all of the changes are complete and there are still more changes to introduce as the time becomes proper for them to be made. Many of our directions may be modified as we gain more experience with the merged operation. I might add that the merging of staff is going smoothly and we hope that this will add much to the efficiency of the HMA and HCMS.

THOMAS P. FRISSELL, M.D.

Treasurer's Report

Your Reference Committee next considered the report of the Treasurer. The Committee noted the proposed change from a fiscal year to a calendar year. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGAL COUNSEL

This report covers the calendar year 1970. Your legal counsel opened 1970 with a problem of liaison with the American Bar Association relating to an effort to alter the Rules of Evidence relating to privileged communications by patient to doctor, and received full cooperation from the Hawaii Bar Association delegates.

Your counsel has attended Council Meetings, and has handled administrative calls and matters for the Association as required by your officers, including an in-depth study and opinion relating to the accumulation of vacation by salaried personnel, and general matters relating to the reorganization of Hawaii Medical Association and Honolulu County Medical Society.

The major service by legal counsel in 1970 related to the Workmen's Compensation fee revision preliminary and actual public hearings. The preliminary hearings involved a major portion of three days, and the actual public hearings involved the whole of two days. In both instances preliminary work with potential witnesses and with counsel representing other interested parties involved a considerable period of time.

Your legal counsel has no recommendations.

V. THOMAS RICE

Legal Counsel

Your Reference Committee next considered the report of the Legal Counsel and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COUNSEL

The work of the Legislative Counsel began on Thursday, January 14, 1971, when the first meeting of the HMA Legislative Committee was held at 12:30 P.M. in the Mabel Smyth Building. The meeting was set up to meet with the Chairman of the Health Committee of the House, in order to acquaint him with matters of concern to the HMA during the 1971 Session of the State Legislature.

Among the items of interest to the HMA were:

Medical Practice Act Revision
Drug Abuse
Hawaii State Insurance Plan
Hospital Franchising
Emergency Medical Care
Population Stabilization
No-fault Insurance
Environmental Health
Medical Examiner System
Malpractice Insurance
School Health Aids
Auto Safety—Alcohol content in blood

Unlike the work of previous years, the Legislative Council was assigned the primary function to introduce for passage certain bills designed to improve the conditions under which liability insurance for malpractice could be secured for members of the Medical Association. At the meeting with the Sub-committee on Malpractice Insurance three specific measures were discussed. These measures were:

1. A bill to exempt or exclude the proceedings and the records of peer review committees from discovery proceedings.
2. A bill for a statute of limitations which would prevent a suit from being filed after a lapse of a specified number of years after the date of injury, regardless of the date of discovery of such injury.
3. A bill to codify the doctrine of res ipsa loquitur.

After discussion with the sub-committee, it was decided that the need for the codification of the res ipsa loquitur doctrine was not clear in the State of Hawaii, that unless a more direct showing of such need was made that such bill would not be introduced this session.

The 1970 session of the State enacted Senate Bill 1574-70 as Act 60, which provides immunity from civil liability to any member of a peer review committee of a professional group when such committee carries out its authorized duties. The Act, however, does not prevent the participants in peer review committee proceedings nor the records from being subpoenaed in a subsequent court proceeding. It was felt that immunity from being required to testify as to what transpired at such meetings was necessary to give the review committees sufficient latitude to function effectively in the performance of their duties.

On the question of a statute of limitations in malpractice cases, the existing statute provides for all claims to be filed within two years from the date of injury. However, by judicial construction the two-year period of limitation of actions can be extended in cases where the nature of injury was not known or "discovered" by the complainant. In such cases the two-year period of limitations would begin to run from the date of discovery of such injury, with the net possibility of a suit being filed more than two years after the original date of injury.

Accordingly Senate Bill 591 and House Bill 637 were introduced in the respective houses of the State Legislature to exclude proceedings and records of peer review committees from discovery proceedings; and Senate Bill 592 and House Bill 638 were introduced to provide a supplementary statute of limitation to prevent suits from being filed four years from the date of injury regardless of the date of discovery.

Testimony in support of these measures were presented before the Judiciary Committees of both houses by Dr. John Lowrey, President of the Hawaii Medical Association, and supported by the testimony of Dr. George

Schnack on behalf of the Inter-Professional Relations Committee of the Hawaii Bar Association and the Honolulu County Medical Society.

At the date of this report both bills (House Bills 637 and 638) passed third readings in the House and have been referred to the Senate. The Senate is expected to place HB 637 on the calendar for third reading within the next few days.

Senate Bill 592 on the Statute of Limitations in the Senate has not been reported out. Senate Bill 591 passed two readings in the Senate but final passage has been deferred because of the action taken by the House on House Bill 637. That is, the Senate is using HB 637 as the vehicle for this subject matter and has passed on second reading House Bill 638 and on third reading House Bill 637.

At the hearings on these bills before the Senate Judiciary Committee the charge was made that the peer review committees were concerned primarily with "protecting" the status of the medical profession and that little attempt was made to help the cause of patients who were injured by the malpractice of the doctors. Obviously, this was a false picture of the purpose and the functioning of the Medical Peer Review Committee.

The spokesmen for the Medical Association, Dr. John Lowrey, Dr. George Goto and Dr. George Schnack, defended the work of the medical profession and emphasized very strongly the efforts made by the peer review committee to police the activities of their own members to prevent or reduce the incidence of malpractice. In this connection it was the recommendation of Dr. George Goto, concurred in by the Legislative Council, to the Legislative Committee of the HMA that the cause of plaintiffs should be supported by the Medical Association.

Specifically by amending Section 3(h)(6) of the Bylaws, the HMA should make available the committee of specialists and/or general practitioners not only to assist in the defense of a case against the doctor but also, in a proper case where malpractice is found, to assist the plaintiff's cause. The recommendation was based on the theory that the peer review committee, if it is to function properly, should not only work for the interest of the doctor who is maligned, but also for the interest of the member of the public who may have been injured to pursue his case expeditiously with the cooperation of the Medical Association. The Legislative Committee accepted the recommendation and moved that the recommendation be referred to the appropriate body of the County Societies for their action. A reply was made by the Honolulu County Society to the effect that the matter was under consideration, that it would take approximately three months for the proposal to be studied and discussed sufficiently for any definitive action to be taken up by the Society. Another recommendation made by the Legislative Council, and it seems that this recommendation had been made previously, was that the Medical Association's "Legislative Program" be determined early enough, that is in the interim between the adjournment of a session and the opening of the next session, so that the necessary work to present their case for the Legislator's could be taken up before the session convened on January 15 of each year. The legislative program should be completed by October, allowing several months in which the appropriate committees or members of the Legislature could be contacted and the programs discussed.

In this connection it was recommended that the entertainment fund of $1,000 be used expeditiously throughout the year in order to establish a strong working relationship with the members of the Legislature. The formulation of the legislative program would dictate the manner and the occasions through which the Legislators could be contacted and the rapport established.

The Legislative Counsel would like to express its appreciation for the time and conscientious efforts of the President of the HMA, Dr. John Lowrey; the Chairman of the Legislative Committee, Dr. Richard K. C. Lee; the Vice Chairman of the Legislative Committee and Legislative Commissioner, Dr. George Goto; Senator George Mills; and the Legislative Secretary, Mrs. Becky Kendro.

The Legislative Counsel believes that the bridge between the HMA and the Legislature should not be limited to contacts with the Health Committee and the chairman and members of said committee in the respective houses, but that rapport should be established with the other leaders of the Legislature including the chairman and members of the Judiciary Ways and Means and Finance Committees of both houses.

I would like to express my appreciation for the opportunity to work with the Hawaii Medical Association as its Legislative Counsel.

BEN F. KAITO

Legislative Counsel

Your Reference Committee next considered the report of the Legislative Counsel and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MABEL SMYTH BOARD OF MANAGEMENT

The Board of Management of the Mabel L. Smyth Memorial Building met quarterly. To meet our budget, the building rentals were increased 10% for the first floor, 5% for the second floor, and 10% for the Physicians Exchange service. The air-conditioning of the building was completed.

Eight members were added to the Exchange, which averaged 23,399 calls per month, for a yearly total of 280,790 calls.

We are in the process of trading in all the old messagemates for the latest model from G.E. These are more compact and should require less maintenance.

Two meetings were held with the HMA Site Committee and members of the Queen's Medical Center. Negotiations are under way to provide 3,025 additional square feet of office space to HMA–HCMS by adding a floor over the auditorium.

CARL H. LUM, M.D.

Mabel Smyth Board

Your Reference Committee next considered the report of the Mabel Smyth Board of Management and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII COUNTY

The Hawaii County Medical Society held regular monthly meetings in 1970.

At the January 16 meeting the society was pleased to have Drs. George Mills, President of HMA, and John Lowrey, President-elect, present to discuss problems facing the AMA, HMA and the medical profession in general.

The problems of Drug Abuse were presented by Dr. John Stephenson on February 20. After this discussion, the shortage of physicians in Hawaii County became the topic of the evening. It was announced that there would be a meeting with several community organizations to explore possibilities to bring doctors to Hawaii.

At subsequent meetings the members listened to lectures such as

"Medical Treatment of Cholecystitis"
"Medicine and Religion (Film: A Storm A Strife)"
"Diagnosis and Treatment of Acute Respiratory Failure"

"Projected Plans for Student Health Services on Hilo Campus"
"Pending Federal Health Legislation"
"Current Status of Cancer Chemotherapy"
"Recent Experience with Renal Dialysis & Transplantation"
"Rubella Immunization Program—Followup and Surveillance"
"Current Use of Tests in Thyroid Disease"

The County Society has continued to support a Scholarship Program (not necessarily limited to medical students). There has been some discussion regarding change from out-right donation to low-interest loans. It was felt by many members that this should lead to a much larger reserve in the Trust Fund and that this would not create an unreasonable burden for the recipients, since repayment would not be asked for (nor interest) until these students are in practice or on regular salaries. No action has yet been taken.

Public programs, such as the Diabetes Survey and the Rubella Vaccination effort, were fully supported by the Society.

VERNE ADAMS, M.D.

Hawaii County

Your Reference Committee next considered the report from Hawaii County. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HONOLULU COUNTY

This report is basically a continuation of last year's.

The merging of the HMA and HCMS administrative staffs has been working well with apparently increased efficiency of personnel and possibly decreased costs.

The Community Health Planning involvement of the Society has rapidly become more extensive and of more concern to us.

The recent unfortunate death of Mr. William Bowman comes just when he had the Foundation for Medical Care in high gear. However, his work and ideas will be continued. The Foundation becomes even more important to physicians in view of Professional Standards Review Organization (PSRO) and Health Maintenance (HMO) programs.

Peer review studies continue steadily, albeit slowly, because no one is yet sure how PSRO will fit in or how comprehensive peer review eventually must be.

The professional liability insurance problem seems to have been solved by hard-working Dr. Alan Pavel and his committee. A vote of thanks is due to Drs. Pavel and Frank McDowell for their hard work, thoroughness, and expertise on this matter.

The main thing that is obvious is the increasing governmental intervention, good intentioned or not, in the practice of medicine which requires more and more time on the part of officers and committee members at numerous meetings, etc. This is time which could well be spent taking care of patients. In general, actually, it is time spent in frustrations and I wonder how much longer we will be able to interest our younger colleagues in becoming active in medical association affairs.

THOMAS P. FRISSELL, M.D.

Honolulu County

Your Reference Committee next considered the report from Honolulu County and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

KAUAI COUNTY

The Kauai County Medical Society held four regular meetings during the year 1970.

On February 2, 1970, a meeting was held with the presence of Dr. John Lowrey, president-elect of HMA; Dr. George Mills, president of the HMA; Dr. Ralph Berry of the Department of Health, and Dr. Uehara and Dr. Morris of the Maui Medical Society who enlightened the members of the Kauai County Medical Society of the relationship of the Department of Health to the various county and state hospitals.

In February of 1970, four students from the high schools on Kauai were sent to Honolulu for the Career Day program. These students in attendance were: M. Kagawa, H. Kosaki, J. Aqui and Rosemarie Tamura.

In February 12, 1970, a Heart and Husband program was presented at the Lihue Parish Hall in cooperation with the Woman's Auxiliary Society to the Medical Society with a good attendance.

On May 11, 1970, the Society held its second regular meeting with Dr. John F. Murray of UC San Francisco, giving a talk on the diagnosis and treatment of acute respiratory failure.

On May 28, 1970, the County Society in cooperation with the various organizations on the island, conducted a disaster drill under the Civil Defense Program with an industrial explosion occurring at the Nawiliwili Harbor.

Toward the end of October, 1970, the Society, cosponsored with the Lions Club a diabetic detection drive for the whole island of Kauai.

Dr. Fred Ansfield, an expert on Cancer Therapy, was on the island of Kauai in the early part of November giving a series of lectures and talks to the physicians on the island.

Evalani Halemanu was presented to the Kauai County Medical Society as being the Kauai Heart of the Year for having a valvular replacement and has done remarkably and is working at the present time.

The Society also continued to endorse the program of the Department of Health in its continuation of the Rubella program for the school children in the early part of December and also endorsed the administration of a booster dose of oral polio vaccine to the school children in the various regions on Kauai.

The last meeting of the Society was held on December 1, 1970, at which time the election of officers was held for the year 1971.

As can be seen from the above activities, the Kauai County Medical Society did have a productive and successful year for 1970.

CHARLES CUSTER, M.D.

Kauai County

Your Reference Committee next considered the report from Kauai County and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MAUI COUNTY

The ups and downs of life were experienced in 1970 by the Maui County Medical Society and its members. Individually and as teams, the members continue to give service to the many voluntary and governmental agencies. The Diabetes Detection program is now in firm hands. The Careers program continues to expand; the Society received a Charter from B.S.A. for Medical Explorer Scout Post (including wahines—women's Lib?).

Political involvement was highly educational for many members—with assistance from HMA, the legislative ear was bent enough to produce study of Act 97 hospitals by the Legislative Auditor. Workmen's Compensation hearings were well attended on Molokai and Maui. In July,

cold beer was shared with the Maui county and state elected officials before the fireworks of the election in the fall.

Shigellosis reared its bottom on Maui first in April, then in August. Some of this spread and almost caused the downfall of the Mayor in his election (shades of Persian Empire).

The biggest project was educational program in prepaid plans. In June, Dr. Phillip Chu from Kaiser Permanente addressed the Society; in July, Al Yuen from HMSA presented multi-panel concept; in August, Dr. George Mills and Mr. Bowman from Hawaii Foundation presented the Foundation's program. The Society then attempted to reach into the Hotel-ILWU negotiations with the assist of the Foundation, only too late.

The year closed with a gala Christmas Party on December 12, 1970.

SAKAE UEHARA, M.D.

Maui County

Your Reference Committee next considered the report from Maui County and recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

EXECUTIVE DIRECTOR

The merging of the staff of the Honolulu County Medical Society and that of the Hawaii Medical Association has been generally accomplished. Not all of the recommendations in the report of Peat, Marwick, and Mitchell have been carried out as directed by the House of Delegates, but certain basic actions have been accomplished.

The present staff now consists of the Executive Director, two assistants, one in fiscal and business management and one in committee activities, an accountant, two record and accounting clerks, four staff secretaries, a machine operator, a part-time printer, an associate editor of the JOURNAL, and the secretary to the Executive Director.

Since the merger last fall, we have had one resignation and replacement. One position has been eliminated and one added.

The recommendation of the study concerning the joint housing for our subsidiary has not been accomplished and is inhibiting the carrying out of needed reforms in space utilization and in proper staff assignments. Very much remains to be done before a proper level of efficiency is reached.

Other aspects of the reorganization recommendations are very much dependent upon the revision of the bylaws. The report by our auditors on the implementation of the recommendations spells out in some detail the most effective committee structure and merits considerable study by the Charter and Bylaws Committee.

The Common Fund, through which common expenses for both organizations are met, is working very well. We will not be able to give a full evaluation of this operation until we have a full year behind us. This will be in September, 1971.

One of our vexing little problems has to do with the difference in the accounting years of the two setups. This should be clarified if the recommendation of the Finance Committee is approved to change the HMA accounting year to a calendar year. At present we are working in several areas under resolutions of the Council of HMA and the Board of Governors of HCMS. The bylaws should be modified to cover our methodology.

The auditors have indicated approval of the joint responsibility through the presidents and treasurers of the two organizations.

In summary, it is recommended that continued efforts be made to implement the housing portion of the recommendations, that the bylaws be amended to provide more flexibility in the committee structure, and to provide for our continued financing methods.

H. TOM THORSON

Executive Director

Your Reference Committee next considered the report of the Executive Director. Since the last paragraph of the report was intended to be presented in the form of recommendations, your Committee recommends that the last paragraph read as follows: "RECOMMENDATIONS: (1) That continued efforts be made to implement the housing portion of the recommendations as set forth in the report of Peat, Marwick and Mitchell; (2) That the bylaws be amended to provide more flexibility in the committee structure; and (3) That the concept of the financing methods (i.e. Common Fund) be continued."

Your Committee recommends approval of the report and recommendations as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

Resolution No. 5

This resolution relates to the bylaws and asks that the Council of the HMA be given permission to proceed with the implementation of any bylaws changes recommended by the Bylaws Committee prior to the next meeting of the House of Delegates meeting. Your committee felt that this resolution was sound and recommends that this resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 5 be adopted. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 5 AS ADOPTED

Re: Bylaws

WHEREAS, the bylaws of the Hawaii Medieal Association make provision for nearly sixty standing committees, and

WHEREAS, the description of the duties of these committees does not permit flexibility to meet changing conditions, and

WHEREAS, the merging of staff of the Honolulu County Medical Society and the Hawaii Medical Association has resulted in a committee structure of more than eighty committees served by a single staff, and

WHEREAS, administrative studies have recommended a change in the committee structure, and

WHEREAS, the Bylaws Committee will study and make recommendations to the House of Delegates relative to amendments to the bylaws governing the committee structure, be it

Resolved, that the Council may revise the committee structure as established by the bylaws and make such reassignments of duties as it deems prudent, pending the analysis and recommendations of the Bylaws Committee for consideration by the House of Delegates at its next regular or special meeting.

Submitted by HARRY L. ARNOLD, JR., M.D.

Resolution No. 6

This resolution relates to an assistant to the President. A full and complete discussion on the resolution was held and testimony was presented by the President and President-elect. Your Committee recommends that the "Resolved" in the resolution be changed to read: "that

the Council of the HMA establish, if feasible, a position on the staff at the professional level. . . ."

ACTION:

The Chairman recommended that Resolution No. 6 be adopted. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 6 AS ADOPTED

Re: Assistant to the President

WHEREAS, the medical profession is in a process of re-evaluating the health care delivery system, and

WHEREAS, other agencies both government and private are involved in the development of new methods of delivery of such services, and

WHEREAS, the rate of change is accelerating, and

WHEREAS, the demands on the profession indicate the developing need for closer liaison with all agencies, public and private, and

WHEREAS, it is becoming more difficult for the officers of the association to maintain the necessary communications with such agencies, and

WHEREAS, the Council of the Hawaii Medical Association is charged with the administration of the affairs of the Association, now therefore be it

Resolved, that the Council of Hawaii Medical Association establish, if feasible, a position on the staff at the professional level to act as an assistant to the President and officers, to expedite and correlate the functions of the association.

Submitted by THOMAS FRISSELL, M.D.

Resolution No. 7

This resolution relates to the HMA Study on the Quality of Personel Medical Care and continuation of the Study into the cost analysis portion. Your Committee recommends that this resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 7 be adopted. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 7 AS ADOPTED

Re: HMA Study on Quality of Personal Medical Care

WHEREAS, the Hawaii Medical Association saw fit to retain the University of Michigan to evaluate the quality of personal medical care in Hawaii, and

WHEREAS, Dr. Beverly Payne has completed a portion of the study and made his preliminary report to the hospitals, and

WHEREAS, the report on ambulatory care is scheduled to be made in the near future, and

WHEREAS, further studies need to be done under the original projection of the study, now therefore be it

Resolved, that the HMA Study on the Quality of Personal Medical Care be continued into the next stage encompassing the cost analysis of medical care in Hawaii, and be it further

Resolved, that the Council of the Hawaii Medical Association explore the sources of funds to complete the study.

Submitted by THOMAS FRISSELL, M.D.

ACTION:

The Chairman moved adoption of this report as a whole. There were objeetions.

It was moved and seeonded to reeonsider the report of the Treasurer. The motion was defeated.

The Chairman moved adoption of this report as a whole. It was adopted.

INSURANCE AND MEDICAL SERVICES REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 20 physicians and received testimony on the various resolutions and reports to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

ADJUDICATION

The Adjudication Committee of the Hawaii Medical Association did not meet during 1970 as no business was referred to this committee.

ROY I. IRITANI, M.D.

Adjudication

Your Reference Committee considered the report of the Adjudication Committee. Your Committee recommends approval of this report:

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AMA-EDUCATION RESEARCH FOUNDATION

The AMA-ERF Committee again stresses the need for funds for the medical school. The AMA-ERF Headquarters in Chicago sent out a Newsletter dated October, 1970 to all physicians and Woman's Auxiliary members in our State emphasizing the need for additional funds. For the year 1970, a total of $7,519.13 was contributed in the State of Hawaii of which $1,830.00 were contributed by the physicians, and $5,689.13 by the Woman's Auxiliary. For the year 1970 a check from the AMA-ERF representing contributions earmarked by donors for the University of Hawaii School of Medicine will be presented to the University of Hawaii in the amount of $5,103.94 at the HMA's Annual Banquet on May 1, 1971.

The committee has no change in plans or a budget request at this time.

ROBERT T. S. JIM, M.D.

AMA-ERF

Your Committee next considered the report of the AMA-ERF Committee. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE FOR AMA CLINICAL CONVENTION

The Committee set up for the 1975 Clinical Session of the American Medical Association did not have any formal meetings. At the AMA Clinical Session in Boston in 1970 it was voted by the House of Delegates that Hawaii would be the site for the 1975 AMA Clinical Convention. We have obtained copies of many proposals from various travel agencies. All proposals have been forwarded to Mr. Wayne Burmeister, Director of Conventions of the AMA.

Sometime during 1971, representatives from the AMA will be in Hawaii for a site visit and to select its headquarters hotel.

GEORGE H. MILLS, M.D.

AMA Clinical Session, Ad Hoc

Your Committee next considered the report of the Ad Hoc Committee on the AMA Clinical Convention.

Your Reference Committee commends Dr. George Mills on his diligent efforts in obtaining Hawaii for the site of the 1975 Clinical Session of the AMA. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AMA DELEGATE

In this brief report I will review some of the pertinent issues that were deliberated at the House of delegates meeting during 1970. In general, most issues reflect the intense pressure for change in the health care system of this country.

In the area of medical education, there was discussion regarding modification of the conventional system of four years of pre-med, four years of medical school, and hospital-centered postgraduate work. There is strong feeling for a change to three years each of undergraduate and graduate work. It is advocated that a greater part of the clinical training of an internship and residency be done in a private practicing physician's office.

These changes would allow for shortening of the period of undergraduate and graduate education and would provide the young doctors of this country a first-hand exposure to the mainstream of medical care. It would also allow many qualified doctors in teaching positions to be released to provide direct patient care which would help solve the dilemma of our 40,000 physician shortage.

Peer review was a constant topic of discussion. The concern here is that this program is not working and hence the job is not getting done. The House of delegates support the concept that physicians must be aggressive and move into the front line of responsibility in order to establish effective implementation of this system.

The issue of the critical level of medical manpower received a great deal of attention during the two sessions in 1970. There is pressure for more medical schools —larger classes and wider economic support for medical students.

The use of allied medical personnel and physician assistants is gaining momentum throughout the country. However, the smooth and rapid development of this new source of manpower is being slowed by problems of reimbursement schedules—scope of training programs —legality of service — certification and patient acceptance.

There was discussion regarding neighborhood health centers and Health Maintenance organizations (HMO). It is imperative that the local physician and his medical society play an active part in the research and development of these new systems.

At the Clinical meeting in Boston, the House of Delegates accepted Hawaii as the site for the 1975 Clinical Session. This is a tremendous asset to Hawaii and the entire health care system of the Pacific basin.

In conclusion, I would like to recommend that (1) the constitution and bylaws of the Hawaii Medical Association be amended where necessary to provide for active membership for medical students, interns and residents, and that equitable dues adjustment be instituted (2) the appropriate committee of the Hawaii Medical Association be utilized to allow active participation by the HMA in the development of HMO's and community health centers.

GEORGE H. MILLS, M.D.

AMA Delegate

Your Committee next considered the report of the AMA Delegate. It should be noted that the revised Bylaws provides for the membership of interns, residents and medical students, but it does not mention any waiver of dues for the medical students, and your Reference Committee recommends that this be brought to the attention of the Bylaws and Parliamentary Committee.

Your Commitec further recommends that in Recommendation No. 1 the word "participation" be substituted for the word "membership." Your Committee recommends the approval of Recommendations No. 1 and 2.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON EDUCATION AND SCIENTIFIC RESEARCH

This Commission consists of the following four committees — Medical Education, Hospital, Publications, and AMA-ERF.

The committee reports clearly state the major activities and problems of each committee. Most of the activities of this Commission involved the dedicated Medical Education Committee and this committee, in particular, has made progress in many avenues this past year.

Inasmuch as most of the activities of this Commission have been mentioned in the committee reports, I would only like to emphasize several general factors.

1. Continuing Medical Education must be instituted on a more rational and effective basis. The HMA's Study on the Quality of Personal Medical Care concerning the hospitals has been completed and presently should form the basis for future medical education within the hospitals. The contemplated Study of Office Care should be under the direction of HMA and its information should form the basis of a new, unique, rational basis for medical education in regard to ambulatory care. The HMA should be proud of its present achievements in this area, and hopefully will fully utilize the information gained to make it potentially one of the leading states in the nation in providing rational and effective leadership in continuing medical education. The Continuing Health Education Council (CHEC) has been rejuvenated and appears that it will be active in our quest for a format and evaluation for future medical education.

2. Medical research is gaining momentum in our community and the present HMA role in research should be reassessed. At the HMA Council meeting of September 18, 1970, this Commission recommended that the AMA-ERF Committee be renamed the Scientific Research Committee. In the past this committee has performed a perfunctory role in aiding the Woman's Auxiliary and their annual AMA-ERF program. It was recommended to the Council that the functions of this committee be changed and to include the following: (a) encourage participation by physicians and the community to contribute to the medical school and research through the AMA-ERF; (b) encourage research by institutions and individual physicians; (c) gather information as to resources and research; i.e., the availability of an electron microscope, statistician, medical illustrator, etc.; (d) disseminate information to the public as to the type and quality of scientific research conducted in Hawaii; and (e) assist and obtain contributions for research.

The Council approved the above recommendations.

3. The four-year medical school should become a reality in the near future. The HMA has supported the medical school and this positive support was again given to the Legislature this past year. The future destiny of the medical school and the community physicians appears to be in the hands of the negotiator whose task it will be to effectively reconcile delicate ties between the hospitals and the medical school. This endeavor does not involve HMA directly. Nevertheless, the results of the negotiator could seriously effect such factors as future town-and-gown relationships, selective or widespread effect on physicians medical education and ultimately the patient in terms of continuity, cost, and type of patient care.

Economics is not the primary concern of most physi-

cians, although this has been alluded to by some sectors. The cost, continuity, and type of care to preserve existing physician-patient relations is of more concern. The factor of economics is more likely to affect a surgical specialist in Honolulu, but this can be compensated in an individual's practice by only allowing an economically feasible portion of their practice to be utilized for teaching purposes alone. If a University Service, which is autonomous and as presented in the excellent "McDermott Report" is to be the ultimate answer, will it be advantageous to the physicians and patients, and to Hawaii in terms of cost, continuity, or care and quality of care?

4. Better relationships and understanding between our existing hospitals and community groups are needed. It would appear that HMA should be the catalyst to achieve these ends and that HMA should take the initiative and responsibility to break down old barriers and establish new relationships that will help to achieve and establish our common goal—improved patient care. To this end it is felt that the hospital committee should be revitalized and promote interhospital understanding and discussion of mutual problems with HMA being the common meeting ground for this forum.

RECOMMENDATIONS: (1) That the next Medical Education Committee continue its efforts to establish a rational and effective continuing medical education program, and that this committee be in charge of the outpatient care portion of the HMA's Study on the Quality of Personal Medical Care. (2) That the AMA-ERF Committee be renamed the Scientific Research Committee and that its functions include (a) encourage participation by physicians and the community to contribute to the medical school and research through the AMA-ERF; (b) encourage research by institutions and individual physicians; (c) gather information as to resources and research; i.e. the availability of an electron microscope, statistician, medical illustrator, etc.; (d) disseminate information to the public as to the type and quality of scientific research conducted in Hawaii; and (e) assist and obtain contributions for research. (3) That the HMA assist, if requested, in the future negotiations between the medical school and hospitals to achieve the most ideal method of improving continual medical education and patient care. (4) That the Hospital Committee be revitalized to promote interhospital understanding and discussion of mutual problems with HMA becoming the common meeting ground for this forum.

WINFRED Y. LEE, M.D.

Commission on Education and Scientific Research

Your Committee next considered the report from the Commission on Education and Scientific Research. A full and complete discussion of the subject was held. Your Committee recommends that in Recommendation No. 2 that the word "in" be substituted for the word "and". Your Committee further recommends that in Recommendation No. 3 that the words "assist if requested" be deleted and the words "offer their assistance through the Medical Education Committee" be inserted. Your Committee recommends approval of Recommendations No. 1, 2, 3 and 4 as amended.

ACTION:

A motion was made and seconded to reword Recommendation No. 3 as follows: "That the HMA offer their assistance through the proper committee in the future negotiations between the medical school and hospitals. . . ." The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON MEDICAL SERVICES

The Commissioner attended most of the meetings of the various committees in his commission, and does not wish to duplicate the reports of the individual committee chairmen.

This is a time of tremendous ferment in medical services, associated with almost unprecedented public interest in the area, which is played up to the hilt by the news media and the politicians. With self proclaimed, instant experts appearing on every side, it was never more necessary that the medical profession become involved in advising, informing, educating and hopefully guiding the inevitable changes that are going to occur in the delivery of medical services within the next few years.

One realizes fairly well the dilemma of the medical profession in this regard. If it refuses to cooperate at all then it will be blamed as being reactionary and unfeeling; if the profession gives its cooperation, any warnings it may give are soon forgotten and in the event of failure of planned expectations to be achieved, the profession is all too likely to be made the scape goat. Medicaid and Medicare are, of course, two classical examples of this.

Nevertheless, though the commission has no specific recommendations to be made it is felt that the only course to follow is to continue President Lowrey's approach of cooperation rather than confrontation.

JOHN R. WATSON, M.D.

Commission on Medical Services

Your Committee next considered the report from the Commission on Medical Services. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNITY RESEARCH BUREAU

The Community Research Bureau was incorporated to provide an educational and research organization which could receive and disburse funds for the purpose of encouraging:

(1) Needed support for medical education
(2) Research into the broad spectrum of the social and economic aspect of the delivery of health care, and
(3) Directing attention to different methods of providing health care and services.

The Community Research Bureau has been exempted under Section 501 (c) (3). Under this status any contributions made to the Community Research Bureau will be exempted as far as the Internal Revenue Service is concerned. I feel that the Hawaii Medical Association should have a vehicle where contributions can be made for research and educational purposes if the need arises.

RECOMMENDATION: It is recommended that this bureau be continued.

B. ALLEN RICHARDSON, M.D.

Community Research Bureau

Your Committee next considered the report from the Community Research Bureau. Your Committee recommends approval of their recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CRIPPLED CHILDREN

The Crippled Children's Committee has not met during the past year. The chairman, however, has reviewed the minutes of previous meetings and it appears that most of the programs entertained by this committee in the past have had to do with the value of fees in regard to physicians who have worked for and through the Crippled Children's Bureau at the State Health Department. A meeting will be called in the near future to dis-

cuss how the committee can be more intent and how they might supplement and compliment the Children's Bureau and perhaps try to serve in an advisory capacity in this regard.

RECOMMENDATION: Pending the outcome of the next meeting of the Crippled Children's Committee, it is recommended that this committee continue on an ad hoc basis for the next year.

ROBERT D. BART, JR., M.D.

Crippled Children

Your Committee next considered the report from the Crippled Children Committee. Your Committee recommends that in their recommendation that the words "continue on an ad hoc basis for the next year" be deleted and the following inserted "meet regularly and endeavor to establish more active dialogue with the Crippled Children's Bureau at the State Health Department." Your Committee recommends approval of the recommendation as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FEE SURVEY

The Fee Survey Committee is pleased to report that the *1970 Relative Value Studies* have been completed and circulated to the membership. As per the mandate of the House of Delegates, we conducted six educational seminars throughout the State. A few minute errors have been found and an errata sheet will be mailed to the purchasers of the RVS.

BUDGET REQUEST:

Issuance of Errata	$100.00
Spot Surveys	400.00

RECOMMENDATIONS: The committee again recommends that periodic spot surveys be done for the purpose of adding new procedures at the discretion of the committee.

FREDERICK B. WARSHAUER, M.D.

Fee Survey

Your Committee next considered the report of the Fee Survey Committee. Your Committee commends this hard working committee for their diligent and thorough revision of the *Relative Value Studies*. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAMPAC

Purpose of American Medical Political Action Committee: To develop a membership and, thereby, funds to help put people into public office who are sympathetic towards high standards of medicine, free choice of physician and private enterprise.

Activities of 1970 and 1971: The billings that have gone out from the County Medical Societies of the State have included HAMPAC news and they have had fair results. There have been specific activities by the board members to increase the membership other than as stated above. A recent mailing has gone out to increase the membership and, thereby, the funds for the above purposes. Contributions were given to local and U. S. legislatures and supported 80% of those who gained office.

Goals and Recommendations: It is my belief that a great deal can be done to increase the membership of HAMPAC in the form of dinners and speeches given by well-known local State Legislators and U. S. Congressmen, also the board members could be giving talks before groups of doctors as to the purposes and accomplishments of HAMPAC. It is recommended that new members of the board be appointed and that the activities as outlined above be done so that the effectiveness of HAMPAC can be felt in the State as it is in many other states. If conditions are allowed to continue as they have been in the last five years, medicine as we know it today will not exist in another five years. Every effort should be made to make physicians conscious of this and be willing to support HAMPAC regardless of their party affiliations. It should be well known that HAMPAC is not a partisan organization but is an organization of physicians for the betterment of their profession.

DON E. POULSON, M.D.

HAMPAC

Your Committee next considered the report from HAMPAC. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HOSPITAL

The Committee met once at which time it was decided that the committee be disbanded and its functions, as spelled out in the HMA Bylaws, be assumed by other standing committees. The Chairman of the Commission on Education and Scientific Research disagreed with this course of action and felt that perhaps the only way the committee could effectively communicate with the hospitals would be for the HMA to negotiate with the Hospital Association to enable the HMA to send a representative to their meetings.

The HMA Council mandated that "the Hospital Committee continue to function following a revision of its present function so that it may hopefully become a meeting ground for physicians and hospitals in inter-hospital relations relative to HMA."

The Chairman, gave this mandate deep thought and research. He believed their goal to be "utopian, unrealistic and unworkable" no matter how the functions of the committee are revised and subsequently resigned.

WINFRED Y. LEE, M.D.

Hospital

Your Committee next considered the report of the Hospital Committee. A full and complete discussion was held. Your Reference Committee recommends that the new Hospital Committee meet regularly. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

INDIGENT MEDICAL CARE

This committee met as a whole on two occasions and concerned itself with the entire Department of Social Services program. We had dialogue with Mr. Robert Millar and Dr. Alice Dahlby from DSS and had useful exchange of information and concerns. It appears that DSS is sympathetic toward HMA's concern about the operation of this program, especially the substandard remuneration. The stricture in the latter regards is at the legislative appropriations level, and DSS seeks the Association's help in reinforcing the DSS request for increase in the fee schedule. It was agreed that regular channels of communication between DSS and HMA should be established.

The committee began by trying to establish a position statement relative to the medical care of the indigent. This obviously is a sizable undertaking, and no definitive information was obtained.

The committee also felt that its name should be changed to "Committee on Health Care for the Underprivileged" to be in concert with the concerns about undignified identification of this group.

RECOMMENDATIONS: (1) Change name of committee to "Committee on Health Care of the Underprivileged." (2) Establish close liaison and working relationship with DSS. (3) Develop position statement on the health care of the needy.

RICHARD T. MAMIYA, M.D.

Indigent Medical Care

Your Committee next considered the report of the Indigent Medical Care Committee. A full and complete discussion was held. Your Committee recommends that the 3rd paragraph be deleted. Your Committee further recommends that Recommendations No. 1 and 3 be deleted. Your Reference Committee recommends approval of this report as amended.

ACTION:

It was moved and seconded that the report and recommendations of the Indigent Medical Care Committee be accepted as originally presented rather than the recommendation of the Reference Committee. The Chairman moved adoption of this portion of the report. It was adopted.

PHARMACY

The Pharmacy Committee held one meeting during the year to discuss the HMA's position on generic drugs. A position paper on generic drugs was developed and approved by the HMA Council. The statement was subsequently used as testimony before various committees of the Legislature. Other items of legislation relating to drugs, pharmacists, etc. were reviewed by the committee.

There are no recommendations.

DANIEL D. PALMER, M.D.

Pharmacy

Your Committee next considered the report of the Pharmacy Committee. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL CARE PLANS AND PEER REVIEW

The reports of the Medical Care Plans Committee and Peer Review Committee are being combined because of the fact that the Peer Review Committee came into being as a result of the recommendation of the Medical Care Plans Committee and because they are both chaired by the same person.

The Medical Care Plans Committee held one meeting during the year to discuss the Hawaii Health Prepayment Act (SB 496-HB 433) which would require employers to provide health insurance for all employees. It was unfortunate that only two committee members were able to attend the meeting. The members present felt the measure left many questions unanswered and were concerned about the number of individuals this would affect. It was felt that this would be a very costly undertaking for the State and that it would be foolish to set up a statewide plan now when it appears that the Federal government will be moving in the same direction within a year or two.

In early 1970 the Medical Care Plans Committee considered a statewide peer review system and presented guidelines on peer review to the Council for their approval. The Council approved the recommendation that the HMA be the coordinator for the statewide peer review system and the following guidelines were adopted: "The primary function of a Peer Review Committee should be education and a concern for the quality of medical care given in the State. Also, (1) The Peer Review Committee should be available to everyone. (2) Members of the Peer Review Committee will be appointed by the county medical societies. The Peer Review Committee will be responsible to the county that appoints it. (3) The members of the Peer Review Committee should be compensated on the HMA level. (4) If grievances or disputes cannot be settled on the county level, the case will go before the HMA State Committee on Peer Review which is composed of the Chairman of the Medical Care Plans Committee, the Commissioner on Medical Services, and one member from each of the county Peer Review committees. (5) Staggered committee appointments are recommended. (6) The composition of the committee, i.e., specialty representation, is left to the county society. (7) A "Frame of reference" should be established to guide the Peer Review Committee.

These guidelines are being reprinted in this report with the hope that they will serve to guide the county medical societies in the establishment of their peer review committees and avoid duplication of effort. The county peer review committees have not all been formed nor become active and it has not been necessary for the State Peer Review Committee to meet.

RECOMMENDATIONS: (1) That an active committee be selected to conduct the business of the Medical Care Plans Committee. (2) That the Chairman of the Medical Care Plans Committee or his representative serve as a member of the Legislative Committee. (3) That there be an improvement in communications between the State and County committees to avoid duplication of energy.

BENJAMIN C. K. TOM, M.D.

Medical Care Plans and Peer Review

Your Committee next considered the report of the Medical Care Plans and Peer Review Committee. Your Reference Committee recommends that in the line of the 3rd paragraph that the word "adequately" be inserted before the word "compensated," and also that the following words "on the HMA level" be deleted. Your Committee recommends that in Recommendation No. 2 that the word "serve" be deleted and the following words inserted "be considered for appointment." Your Committee recommends that Recommendations No. 1, 2, and 3 be approved as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL EDUCATION

Postgraduate Medical Education: The Hawaii Medical Association Study of the Quality of Care in Hawaii is the most important and far reaching study of its kind ever undertaken by a medical society. It has already had a definite effect on the hospitals which were involved in the Study and this effect should increase as the Hospital Staffs become more adept at utilizing the medical audit as a tool for learning. During the next year, the data from the outpatient portion of the study should become available. Your committee strongly recommends that this data be presented to the physicians involved in the Study at a series of seminars similar to the ones for the hospital portion of the Study. Your committee recommends that the HMA through its Medical Education Committee assume the responsibility for these seminars.

Graduate Medical Education: This subcommittee has

had several meetings with the Directors of Medical Education of the hospitals with graduate medical education programs. More insight has been gained regarding the problems and anxieties. It is obvious that the impact of a degree granting program at the University of Hawaii will create new and different problems. What responsibility the HMA has in regards to these problems is not clear. However, it was obvious that the D.M.E.'s were reluctant to discontinue the meetings and therefore have some hope that the HMA may be of some help. The committee recommends that the HMA continue through its Medical Education Committee, to show its support and encouragement to the physicians involved in graduate training programs and offer its good services in the delicate negotiations which are about to begin with the University.

Undergraduate Medical Education: Your Committee reviewed the report of a committee which studied Medical Education at the University of Hawaii ("The McDermott Report"). Whereas the committee was not in agreement with the entire content of the report, they were unanimously in support of the development of a degree granting program at the University of Hawaii basing the clinical portion of that program on a multihospital system utilizing the existing community hospitals.

Your committee feels that such a program, if it is well conceived, would have a profound beneficial effect on the profession and should be encouraged.

BUDGET REQUEST:

Educational Seminars $5,000.00

RECOMMENDATIONS: (1) That the data from the outpatient portion of the HMA Study on the Quality of Personal Medical Care in Hawaii be presented to the physicians involved in the Study at a series of seminars similar to the ones held for the hospital portion of the Study. (2) That the Medical Education Committee assume the responsibility for these seminars. (3) That the HMA continue, through its Medical Education Committee, to show its support and encouragement to the physicians involved in graduate training programs and offer its good services in the delicate negotiations which are about to begin with the University. (4) That the request in the amount of $5,000 for educational seminars on the outpatient portion of the Study be approved.

MAX G. BOTTICELLI, M.D.

Medical Education

Your Committee next considered the report of the Medical Education Committee. A full and complete discussion was held. Your Committee recommends that in Recommendation No. 1 the word "all" be substituted for the word "the," and that the words "involved in the Study" be deleted, and further recommends that the words "similar to the ones held for the hospital portion of the Study" be deleted. Your Committee further recommends that in Recommendation No. 4 that the following words be added to the end of the sentence "and that these funds be disbursed at the discretion of the Council." Your Committee recommends approval of Recommendations No. 1, 2, 3, and 4 as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEGOTIATING

The Negotiating Committee held one meeting during the year. The purpose of the meeting was to negotiate with the Veteran's Administration for a conversion factor to be used in determination of fees for service to VA patients. A conversion factor of 7.0 was requested and to date we have had no confirmation from the VA. Followup on this is pending.

CHEW MUNG LUM, M.D.

Negotiating

Your Committee next considered the report of the Negotiating Committee. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WORKMEN'S COMPENSATION

This committee set forth the following principles from which it would try to negotiate with the Director of Labor. That the prevailing fee should be paid on the usual and customary and reasonable concept, and that once a base year is established our fees should be adjusted up or down in accordance with the cost of Consumer's Price Index on a yearly basis.

Mr. Hasegawa's contention was that he was unable to determine what our prevailing fee was, because our doctors participated with HMSA, Foundation, DSS and Aetna. He therefore proposed a conversion factor of 6 for everyone except for Board Certified Surgeons who would be paid on a conversion factor of 7.5.

Because of his proposal the members of this committee were polled, and it was the unanimous decision that such dual fee schedule was not of the best interest of the society and would only tend to divide and create dissension in our society.

Public hearings were held in May and again in December of last year. At that time all those who were interested were invited to testify but unfortunately those who complained the most were not the ones who were willing to give up their time to testify. In the December hearing the insurance carriers and labor representatives re-inforced our concept that the fairest method of payment was the usual and customary method, which was most gratifying to the members of this committee.

Nothing more was heard until this legislative session, when Mr. Hasegawa testified on the House Labor Committee that his findings from the last public hearing will be published in May. The results of his findings will be considered as the base year and thereafter our fees will fluctuate according to fall or rise of the Consumer's Price Index which is published yearly.

It was noted that the orthopedists, neurosurgeons and Straub Clinic were represented by Mr. Walter Chuck at the public hearings with the Workmen's Compensation Bureau.

Again Mr. Rice, our attorney, was most useful because of his previous experience and knowledge of the workings of our society for the past 15 years.

As chairman of this committee, I would like to request that $5,000.00 be budgeted for this committee for legal fees if and when it becomes necessary.

I would like to take this opportunity to thank the members of my committee and Mrs. Becky Kendro for her succinct diplomacy and efficiency.

BUDGET REQUEST:

Legal fees $5,000.00

THEODORE T. TOMITA, M.D.

Workmen's Compensation

Your Committee next considered the report of the Workmen's Compensation Committee. Your Committee recommends that the 6th paragraph be deleted and the following substituted. "It was noted that the orthopedists, neurosurgeons and Straub Clinic were represented by Mr. Walter Chuck at the public hearings with the Workmen's Compensation Bureau." Your Committee recommends approval of this report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

Resolution No. 2

This resolution relates to the 1970 RVS. A full and complete discussion was held. Your Committee recommends that this resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 2 be adopted. It was adopted.

RESOLUTION NO. 2 AS ADOPTED

Re: The 1970 Relative Value Studies

WHEREAS, the relative value approach to establishing levels of fees in medicine has been an accepted method for more than fifteen years, and

WHEREAS, the everchanging concepts of medicine and the expanding capabilities of the medical profession necessitate recodifying the descriptions of service, and

WHEREAS, the Hawaii Medical Association published its first Relative Value Studies in 1965 following an in-depth study of the pattern of fees in Hawaii, and

WHEREAS, the 1965 RVS was in general accepted as the standard of relativity of fees in Hawaii both by the medical profession and third party payors, and

WHEREAS, it now becomes necessary to restate the principles of the RVS in light of modern knowledge and in view of experience gained during the past years, and

WHEREAS, the physicians serving on the Fee Survey Committee gave freely of their time over a period of three years to the study of all facets of the problems of a relative value study, and

WHEREAS, they have submitted their recommendations to the Council of the Hawaii Medical Association who accepted the proposal and ordered it printed and distributed to the physicians of the state, and

WHEREAS, the 1970 version of the Hawaii Relative Value Studies is now in general usage by the physicians in Hawaii, now therefore be it

Resolved, that the 1965 RVS be declared obsolete and that the 1970 RVS be declared the official guide for the determination of fees of the Hawaii Medical Association membership, and be it further

Resolved, that insurance carriers and governmental agencies be notified of this action.

Submitted by MAURICE W. NICHOLSON, M.D.

Resolution No. 3

This resolution relates to Peer Review. Your Committee notes that the makeup of the HMA Peer Review Committee has already been established. Your Committee recommends that in the 1st Resolve that the words "member of" be deleted and that the words "consultant to" be inserted. Your Committee recommends that this resolution be adopted as amended.

ACTION:

The Chairman recommended that this resolution be adopted as amended. It was adopted.

RESOLUTION NO. 3 AS ADOPTED

Re: Peer Review

WHEREAS, the Hawaii Society of Internal Medicine (HSIM) is vitally interested in peer review, and

WHEREAS, the HSIM has recently formed a peer review committee within its society, and

WHEREAS, it is obvious there should be close relationship between HSIM Peer Review Committee and the HMA Peer Review Committee, now therefore be it

Resolved, that the chairman of the HSIM Peer Review Committee be appointed as a consultant to the HMA Peer Review Committee and be it further

Resolved, that the HMA Peer Review Committee encourage all county societies to implement their peer review programs without delay.

Submitted by the HAWAII SOCIETY OF INTERNAL MEDICINE

ACTION:

The Chairman moved adoption of this report as a whole as amended. It was adopted.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates

Your Reference Committee met before an audience of approximately twenty physicians and guests and received testimony on the various reports and resolutions submitted to the Committee for consideration and recommendation. Having heard the discussions of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

ARRANGEMENTS

This committee met on numerous occasions. With the meeting being in Honolulu this year, most of the arrangements were made early in the year 1970. Mrs. Heather Akana, Coordinator of the Convention, has again worked with Mr. Harold P. Brown of the Conference Center of the University of Hawaii. The Conference Center has assisted the HMA in planning for the meeting. The meetings will be held in the Moorea Room of the Pacific Ballroom at the Ilikai Hotel. The House of Delegates will also hold its sessions at the Ilikai.

Breakfasts will not be catered this year as there are many fine restaurants at the Ilikai to which the participants at the Convention may be served before the meetings.

The Hawaii Thoracic Society will hold its "Fireside Chats" in the Moorea Room on Tuesday, April 27, 8:00 P.M. These informal discussions have outgrown the facilities at the Mabel Smyth Building.

Exhibits: This year, the pharmaceutical companies, voluntary health agencies, and other organizations bring the total number of exhibits up to 50. The exhibit hall is located within the Pacific Ballroom. Registrants have been encouraged to view the exhibits.

Fishing and Tennis: As usual, these events will be held before the week of the annual meeting and prizes will be awarded at the Sportsmen's Night dinner.

Golf: The golf tournament will be held at the Oahu Country Club and the Waialae Country Club. Golfing arrangements are being handled somewhat differently than in the previous years; that is, players with 0-20 handicaps will play for Low-net and Low-gross prizes at Waialae Country Club and players with handicaps of 20 and above will play for prizes in a satellite tournament at Oahu Country Club. Pharmaceutical representatives (exhibiting at the annual meeting) and visiting doctors have been invited to participate at the Oahu Country Club. This arrangement was due to the inability to accommodate the group at one club.

Bow & Arrow: This tournament is an innovation for the annual meeting activities. The tournament is scheduled for April 23, 24, and 25 on the Island of Hawaii. Considerable planning by the Chairman of the Bow & Arrow Tournament Committee was undertaken. Due to the lack of advance bulletins, there will be few participants. It is hoped that wider coverage will be given for this event next year in order to attract more participants in this fine sport.

Sportsmen's Night: This function will be held at the Waialae Country Club following the golf tournament. Prizes for all four sporting events will be distributed at that time.

Banquet: The banquet will be held at the Ilikai Hotel (Pacific Ballroom). Dinner and entertainment are included in the per capita cost. Cocktails will be served on a no-host basis.

Aloha Committee: Host physicians for the guest speakers were arranged by the Scientific Program Committee.

RECOMMENDATIONS: (1) That next year's committee continue to utilize the services of the Conference Center at the University of Hawaii. (2) That no solicitations of pharmaceutical houses be made for prizes for the sporting events, making the entrance fees cover the expenses for prizes. (3) That next year's committee start its planning early as was done this year in order to expedite the various functions.

R. VARIAN SLOAN, M.D.

Arrangements

Your Reference Committee considered the report of the Arrangements Committee. A full and complete discussion of the subject was held. Your Committee recommends approval of this report and its recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ASSOCIATION OF PROFESSIONS

Representatives of the Hawaii Nurses Association, Hawaii Education Association, Hawaii Psychologists Association, Hawaii Society of CPA's, and the Hawaii Veterinary Medical Association met to lay the groundwork for the formation of an organizational draft leading to the formation of the Association of Professions of Hawaii. There appeared to be a consensus amongst those attending, and those who expressed their desire to participate in such an association, of the mutual advantages in the area of legislation, taxes, and licensure.

RECOMMENDATION: Now that the groundwork has been laid, it is recommended that this committee be continued in view of the interest expressed by other professions of the mutual advantages in forming an association of professions.

LEABERT FERNANDEZ, M.D.

Association of Professions

Your Committee next considered the report of the Association of Professions Committee. A full and complete discussion was held. Your Committee recommends approval of this report and its recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AWARDS & SPECIAL PROJECTS

The committee had one meeting this year at which time nominations for the Robins Award were made and to discuss the Hawaiian Science Fair.

Hawaiian Science Fair: The Hawaiian Science Fair was held April 1-4, 1971, at the Honolulu International Center. The HMA supported this Fair and extended six awards of $15 each. The judges representing the HMA were Drs. William J. Holmes and Robert T. S. Jim. Dr. Jim made the presentation of awards to the following recipients:

"Does Ancestry Affect the Thickness of Your Hair"
Patricia Williams, St. Francis High School
"Platelets and the Heart"
Robert Ericsson, Damien Memorial High School
"Association of Australian Antigen to Viral Hepatitis"
Ann M. Hiyamoto, Kaimuki High School
"Study of Lanice Conchilega on Skin Cancer"
Lynn Murakami, McKinley High School
"Viability of Refrigerated and Frozen Ehrlich Ascites Tumor Cells"
Craig Osaki, Aiea Intermediate School
"The Heart-Coronary Heart Disease"
Tom Nelson, Kalaheo Hillside Intermediate School

The committee is continuing its association with the Inter-Society Science Education Council (ISSEC) of the Hawaiian Academy of Science and Associated Societies, and Dr. Robert A. Nordyke is the HMA representative.

Robins Award: The HMA membership was surveyed relative to the A. H. Robins "Physicians Community Service" Award prior to the committee meeting. The committee selected the recipient and his name will be revealed at the Annual Banquet on May 1, 1971.

BUDGET REQUEST:

Prizes	$ 90.00
Contribution to ISSEC	100.00

K. S. TOM, M.D.

Awards and Special Projects

Your Reference Committee next considered the report of the Awards Committee and recommends approval of the report and budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CAREERS

Health Careers Day was held on February 10, 1971, at the Honolulu International Center. Hawaii Medical Association was one of twenty-two sponsoring organizations. Attendance was estimated at 740 persons although we had hoped to have approximately 3,000 students. It is felt that the main reason for this poor attendance was lack of communication between the schools and the Health Careers Council of Hawaii (HCCH). Evaluation by the students showed approximately 50% gave a grade of A on the exhibits, and 30% gave a grade of B. HMA sponsored an exhibit of SAMA of the U.H. School of Medicine, as well as a booth and hospital tours of 150 students to seven participating hospitals. Approximately thirty physicians took part, donating at least two hours each. The Woman's Auxiliary was extremely helpful and interested in this project and have donated more woman-hours to make it as successful as it was. In the future, we plan to utilize them even further in an attempt to coordinate communication with the various high schools. Our total expenditures were $329. Enclosed is a copy of the expenses; balance of $1,670 is being returned to HMA.

As far as HMA is concerned we hoped to have 300 students visiting the hospitals and were disappointed at the poor attendance; but we must realize that we are reaching more students with less cost and less doctors' time than in any previous year.

The committee was charged with formalizing the Health Careers Council of Hawaii. This was not accomplished and I do not feel that it can be accomplished until we have more cooperation and signs of interest from the schools and students. We are planning to hold another Health Careers Day in the Fall of 1972. Following this, a definite decision can be made regarding the future of the HCCH.

BUDGET REQUEST:

July 1, 1971 thru December 31, 1971	None
January 1, 1972 thru December 31, 1972	$500

H. WILLIAM GOEBERT, JR., M.D.

1970 BUDGET FOR HMA CAREERS COMMITTEE

Income:	
Budgeted	$2,000.00

Expenses:		
Rubber stamp for return address	$ 3.00	
Envelopes	8.00	
HCCH letterhead	13.06	
HMA booth at HIC	39.30	
SAMA Meeting Room	28.50	
Neighbor island transportation	237.00	328.86
BALANCE		$1,671.14

Careers

Your Reference Committee considered the report of the Careers Committee. A full and complete discussion of the subject was held. Your Committee recommends approval of this report and the budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FILIPINO SPEAKERS BUREAU

The Filipino Speakers Bureau met several times during lunch hours and in the evening to make another attempt to establish an active committee. The project for the year was to sponsor medical programs on radio and later on TV. Filipino speaking radio station coordinators and other radio and TV personalities were invited to join the committee to assist in the program.

One radio announcer offered five minutes of his radio broadcasting time each week. Drs. Quintin Uy, Henry Manayan, and myself tape record medical messages and copies were mailed to the studio. At present we plan to tape two medical messages a week and send them to Filipino speaking radio stations on Oahu and the other islands. One TV-Radio personality said a poll can be taken at a later date to determine how the radio program is being received by the viewers and also to learn what types of medical subjects the public would like to hear.

As soon as the radio program is well established, the next venture will be programs on TV.

MANUEL A. ABUNDO, JR., M.D.

Filipino Speakers Bureau

Your Reference Committee considered the report of the Filipino Speakers Bureau. A full and complete discussion of the subject was held. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEALTH MANPOWER

The Health Manpower Committee, recently formed in 1970, held four meetings to consider aspects of health manpower within the State. Members of the committee were encouraged to participate in subcommittees of Comprehensive Health Planning and several members accepted. Attendance at our committee meetings has not been good. We were able to receive some communication regarding the activities of Comprehensive Health Planning, and close liaison with that organization should be maintained.

One meeting was devoted to a presentation by Drs. O'Rourke and Pion concerning health manpower. A questionnaire was circulated relative to the feasibility of employing physician's assistants after it was agreed that the term "physician's assistant" should represent the individual classed as "Type A" as defined by the National Academy of Sciences. The 229 positive responses of 334 returns were further queried by mail and 53 answered affirmatively of the 135 returns that they are seriously interested in utilizing physician's assistants.

The committee felt favorably toward, but did not take any action on, the question of an expression of recognition by HMA for Medical Officers of the Trust Territories.

The committee endorsed a proposal of the Straub Medical Research Institute to evaluate the quality and acceptability of non-physician managed/physician supervised clinics for chronic diseases.

In March a resolution from the Hawaii Nurses Association was received requesting joint discussions with HMA concerning "The Extended Role of the Nurse." This will be acted upon shortly.

RECOMMENDATIONS: (1) That the HMA endorse the definition of "physician's assistant" to be the same as "Type A" defined by the National Academy of Science as follows: "The Type A assistant is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other, more technical, assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physician. He is, thus, distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment." (2) That the HMA support a moratorium for the next two years concerning licensing of new categories. (3) That the HMA endorse and participate in any feasibility studies on physician's assistants that might result from legislation currently being considered. (5) That a "Multidisciplinary Committee" composed of physicians, attorneys, educators, and health planners be formed to look into the broad question of licensure, certification, relicensure and recertification.

H. H. CHUN, M.D.

Health Manpower

Your Reference Committee considered the report of the Health Manpower Committee. A full and complete discussion of the subject was held. Your Committee recommends that Recommendations No. 1, 2, 3, and 5 be approved. Your Committee further recommends that Recommendation No. 4 be deleted. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

JAPANESE SPEAKERS BUREAU

The committee met regularly every two months and discussed projects for KOHO Radio and KIKU-TV.

The medical programs on KOHO Radio were rotated through Team A members including Noboru Akagi, Henry Yokoyama, Naomitsu Tajima, Shigeo Natori, Kazushi Tanaka, Takakazu Fukumura, Keiichi Goshi, and Toshihiko Kawasugi. Team B members consisting of Mitsuo Hattori, Harry Nakata, Richard Sakimoto, Emiko Sakurai, Fumiyo Sugimoto, Yoshiki Ushiyama, Tsuyoshi Yamashita, and Hideo Namiki were called upon when needed for other evenings. These KOHO Radio programs are as popular as ever.

The KIKU program, called *T. V. Shindanshitsu* (diagnostic room), is scheduled twice monthly on Thursday evenings from 7:30-8:30 P.M. and is rotated through all members. One speaker appears with the moderator, Mrs. Oki, while another member receives incoming telephone

calls which he screens and gives to the moderator. Response to this program has been overwhelming.

Other members have voluntecred as speakers for the Senior Citizens and Cancer Society programs. The willingness and devotion of all members have made our projects possible.

Out of the original budget allocated this committee, $120 was spent on visual aid materials and artists' fees. It is felt that the committee can function on an annual budget of $150.

BUDGET REQUEST:

July 1, 1971 thru December 31, 1971..... $ 75
January 1, 1972 thru December 31, 1972.. 150

TOSHIHIKO KAWASUGI, M.D.

Japanese Speakers Bureau

Your Reference Committee considered the report of the Japanese Speakers Bureau. A full and complete discussion of the subject was held. Your Committee recommends approval of this report and its budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON INTERPROFESSIONAL AND PUBLIC RELATIONS

Your Commission, cognizant that we are in the most challenging and critical period in the public affairs of the HMA, has stimulated and encouraged the various committees under its supervision to an active, reactive, and aggressive course.

The Commission wishes to commend the chairmen and members of the various committees for the dedicated, conscientious, and innovative efforts exerted in the various activities and projects mentioncd in their individual committee reports. It was a privilege and an honor to have worked with these men.

The big challenge in the '70s for the HMA is the understanding and management of change, and we must be leaders of change, not resisters. There is a new social conscience developing among the members that is also a part of what is happening in our society. Time and time again this change has been manifesting itself. This is desirous as we enter thc age of accountability and "consumer consciousness."

RECOMMENDATIONS:

(1) That the HMA continue the "dialogue of understanding" with the politicians, lobbying groups, labor, business, and communications media for they are the public or the voice of the public.

(2) That HMA approve the merger of the HMA Woman's Auxiliary Committee with the Advisory Committee to the HCMS Woman's Auxiliary if the Honolulu County approves.

(3) That the HMA pursue the merger of the HMA Public Relations Committee, the HMA News Media Committee, and the HCMS Public Relations Committee in order to achieve a better coordinated and less wasteful effort in public relations and to preclude the confusion that members of both the Association and Society have to go through in order to clarify publicity situations.

(4) That the HMA continue to conduct, through its Public Relations Committee, an Opinion Survey on medical, social, and economic issues vitally affecting the profession once every two years. The committee should be assisted by an appropriately qualified statistician. This way, HMA can better exercise leadership that will conceive and direct the course of changes within medicine and medical care delivery.

(5) That the HMA encourage the Public Relations Committee and other pertinent committees to schedule luncheon get-togethers for the Society spokesmen and media representatives in a give-and-take session for airing problems. This could be the forum for physicians to speak up, stand up, and be counted. The most effective preventive medicine for a bad press coverage is good media relations before, during, and after any newsworthy medical event.

(6) That HMA should continue its efforts to establish an Association of Professions in this State.

(7) That the HMA direct the Public Relations Committee to study the advisability of forming an advisory board of consumers. It would be the responsibility of the Public Relations Committee to develop specific recommendations with regard to make-up and functions of this board. Broad odjectives of this advisory board would be to encourage positive public relations and to provide opportunities for dialogue with the consumers of health care.

(8) That the HMA encourage and support the Medicine and Religion Committee to complete the informational booklet on dying, the dead patient, or in case of serious illness. This will be of great assistance in the management of these cases not only for the physicians but also the other members of the health care teams and the clergy. This will also be of great public service to the community.

CESAR B. DE JESUS, M.D.

Commission on Interprofessional and Public Relations

Your Reference Committee next considered the report of the Commission on Interprofessional and Public Relations. A full and complete discussion on the subject was held. Your Committee recommends changes to the Recommendations as follows:

(1) Delete from the record the second and third sentences. (2) Change the wording to read "That HMA approve the merger of the HMA Woman's Auxiliary Committee with the Advisory Committee to the HCMS Woman's Auxiliary if the Honolulu County approves. (3) Delete the words "and finalize" in the first sentence. (4) Change the second sentence to read "The Committee should be assisted by a bio-statistician" and delete the balance of that sentence. (5) Delete the words "and forming alliances in promoting community health programs" at the end of the first sentence. (6) Reword the first sentence to read: "That HMA should continue its efforts to establish an Association of Professions in this State." Delete last sentence. (7) Reword to read "That the HMA direct the Public Relations Committee to study the advisability of forming an advisory board of consumers. It would be the responsibility of the Public Relations Committee to develop specific recommendations with regard to make-up and functions of this committee. Broad objectives of this advisory committee would be to encourage positive public relations and to provide opportunities for dialogue with the consumers of health care. This report to be presented to the Council and the next House of Delegates." Your Committee recommends approval of Recommendation No. 8. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved the adoption of this portion of the report. There was a motion to amend Recommendation No. 7 to read "That the HMA direct the Public Relations Committee to study the advisability of forming an advisory board of consumers to the Counell." It was noted that the words "advisory board" should be substituted throughout the rest of the recommendation. The motion was earried.

It was moved and seconded to amend the last sentenee of Recommendation No. 4 as follows: "The committee should be assisted by an appropriately qualified statistician."

The Chairman move the adoption of this portion of the report as amended. It was adopted.

COMMISSION ON INTERNAL AFFAIRS

The Arrangements Committee again functioned most efficiently under the seasoned chairmanship of Dr. R. Varian Sloan. The chairmen of the various social and sport events of the annual meeting completed most of the preparations needed in advance and had no major obstacle to hurdle. An innovation this year was the organizing of a bow and arrow tournament. Dr. William Davis should be commended for his efforts in organizing such a fine sporting event. This year, only a handful of participants will be taking advantage of the tournament. It is hoped that there will be greater participation in the bow and arrow tournament in the future—there needs to be greater promotion relative to the tournament. Again, the committee asked two representatives of the Medical Service Representatives of Hawaii to serve on the committee as consultants. These two representatives have been of great assistance to the HMA in planning for the annual meeting.

In recognition of the multifold contribution of the pharmaceutical representatives to our annual meeting each year, Dr. George H. Mills generously donated a perpetual trophy last year on which the name of the Medical Service Representative participating in the HMA annual golf tournament was inscribed. The purchase of a small replica of the bowl has been allotted for in the annual meeting budget for future tournaments.

Details of each tournament are included in the report of the Arrangements Committee.

The Awards & Special Projects Committee selected Drs. William J. Holmes and Robert T. S. Jim to judge and select projects for awards. Dr. Robert Jim was asked to make the presentation of awards at the Hawaiian Academy of Science's Awards Convocation. The Hawaiian Science and Engineering Fair was held at the Honolulu International Center on April 1-4, 1971. The committee also selected the Robins Award recipient whose name will be revealed at the annual banquet on May 1, 1971.

The Bylaws & Parliamentary Committee did not alter the Bylaws during the year due to the reorganizational study on the merger of the HMA-HCMS staff and to the committee structure.

The Chairman of the Scientific Program clearly outlined objectives of the committee so that within a few months 90 per cent of the program was completed. The committee should again utilize the structured course of plan in order to accomplish the objectives with expediency.

Arrangements for the operation of the scientific meeting of 1971 are again being coordinated with the College of Continuing Education and Community Service of the University of Hawaii. The assistance of this organization, under the guidance of Mr. Harold Brown, has prove to be helpful in arranging for the HMA's annual meeting. Through this means, the HMA has been able to decrease its expenses in several areas.

The Ad Hoc Committee to Coordinate the AMA Clinical Session has not had any formal meetings but the Chairman reported that the AMA House of Delegates at its 1970 Clinical Session approved Hawaii as the meeting site for the 1975 AMA Clinical Convention. Planning for this meeting will be handled by the AMA.

RECOMMENDATIONS: (1) That the HMA continue its working relationship with the University of Hawaii's College of Continuing Education and Community Service for the 1972 annual meeting. (2) That the theme of the succeeding year be selected by the Scientific Program Committee and approved by the Council by January of each year. (3) That selection and confirmation, in writing, of all locations and dates of all events—banquet, sportsmen's night, tournaments, etc. be made at least nine months prior to the oncoming HMA meeting. (4) That the Van Poole and Louis Gaspar perpetual golf trophies be retired and that new perpetual trophies be obtained by the Arrangements Committee. (5) That the new perpetual trophies be named in honor of a deserving physician and be retired after ten years. (6) That Dr. Takeo Fujii be commended for his diligent work in arranging the golf tournament and the sportsmen's night dinner at the Waialae Country Club in spite of his heart condition.

COOLIDGE S. WAKAI, M.D.

Commission on Internal Affairs

Your Reference Committee next considered the report of the Commission on Internal Affairs. After a full and complete discussion, your Committee recommends approval of the report and its recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICINE AND RELIGION

The committee held monthly luncheon meetings with physicians and clergymen throughout the past year. The April meeting will be held in the evening with Dr. Milton Diamond as guest speaker. His topic will be "Pornography." The committee is beginning work on a booklet to be entitled "In Case of Serious Illness."

Maui continues to have monthly breakfast meetings with clergymen and physicians.

Attended regional meeting in Salt Lake City where it was felt that physicians and clergymen need more eyeball to eyeball contact. It was also felt that the program of medicine and religion should be gotten to undergraduates as well as postgraduates. It was felt that the committee can greatly help to improve the image of physicians. It was felt that the woman's auxiliary can be used to get better M.D. participation.

The "Someone Cares" program at Santa Ana Community Hospital was also presented and also various medicine-religion programs in medical schools.

BUDGET REQUEST:

Printing of booklet $250.00

FRANCIS H. SOON, M.D.

Medicine and Religion

Your Reference Committee considered the report of the Medicine and Religion Committee. A full and complete discussion was held. Your Committee recommends approval of the report and budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEWS MEDIA

Under the gentle prodding and through the sustained efforts of J. Ronald Brown, the News Media Committee successfully formulated a Joint Code of Cooperation patterned essentially after the Cleveland Code of Cooperation. Inasmuch as this Code is somewhat vague about the physician's responsibilities, a separate Physician's Publicity Code was drawn up to serve as a guideline.

In a February meeting, it was proposed that the Public Relations Committee of the Hawaii Medical Association and the Honolulu County Medical Society hold joint meetings with the News Media Committee and eventually form a joint committee since most members overlap into these committees.

The Committee feels that the annual Medical Journalism Awards as proposed in the 1970 report be continued with a slight increase in the monetary allotment:

Professional Division:

First Prize: $250.00 cash, $10.00 plaque; and $10.00 engraving of the perpetual trophy

Second Prize: $150.00 cash, $10.00 plaque

Educational Division:

First Prize: $50.00 cash, $10.00 plaque

Second Prize: $25.00 cash, $10.00 plaque

TOTAL BUDGET REQUEST: $525.00

RECOMMENDATIONS: (1) That the Code of Cooperation and the Publicity Code for Physicians as approved by the HMA Council on April 9, 1971, be reaffirmed by the House of Delegates. (2) That the intent of the revised Code of Cooperation be implemented as soon as feasible. (3) The Committee should continue the medical journalism awards as proposed. (4) The Committee (or its equivalent) continue as an active grievance committee.

HENRY YOKOYAMA, M.D.

News Media

Your Reference Committee next considered the report of the News Media Committee. A full and complete discussion was held. Your Committee recommends that the budget for the First Prize and Second Prize for the Professional Division be changed to $150 and $50, respectively, and change the total to $325. Your Committee recommends approval of Recommendations No. 1, 2, and 3. Your Committee further recommends that Recommendation No. 4 be reworded as follows: "The Committee or its equivalent continue as an active review committee for the implementation and interpretation of the above mentioned codes." Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved the adoption of this portion of the report. It was voted to amend Recommendation No. 1 as follows: . . . be reaffirmed by the House of Delegates subject to the approval of the Legal Counsel.

The Chairman moved adoption of this portion of the report. It was adopted.

OPERATION PACIFIC

The Operation Pacific Committee continued to function as a mechanism by which HMA members could be contacted for service in the Pacific basin, especially in Polynesia and Micronesia with which the people of Hawaii have a special interest and affinity. An active file of names of HMA members was kept to facilitate getting in touch with those interested in voluntary or contractual service should a request be made to HMA.

Several HMA members had the opportunity to accompany an East-West Center team to Micronesia for a Technology and Development Institute this spring. This was held in conjunction with the annual Micronesian Medical Association meeting. The Micronesian doctors stated that material assistance in the form of books, equipment and drugs is no longer as vital as personal meetings with HMA members both in their home territory and Hawaii. They were especially interested in being able to observe and study the operations of HMA after which they would like to pattern their own medical association.

RECOMMENDATIONS: (1) That HMA concentrate on a person-to-person type of contact with the doctors in the Pacific basin rather than sending them supplies, and (2) That we explore different ways in which we could increase and assist in meaningful personal contacts with the Medical Officers of the Pacific islands.

GEORGE SUZUKI, M.D.

Operation Pacific

Your Reference Committee next considered the report of the Operation Pacific Committee. A full and complete discussion was held. Your Committee recommends approval of the report and its recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

QUACKERY

The Quackery Committee met only once during this past fiscal year. The meeting was called in an attempt to combat the inferences of chiropractic advertisements appearing in the Pali Press and the Windward Shopper. A telephone conversation with one of the managers of the Windward Shopper implied that they would be willing to run medical message-of-the-month type articles in their papers on days in which the chiropractic ads were carried. A follow-up letter from the Quackery Committee was sent, but unfortunately the person originally spoken to had left. We are now in the process of contacting the successor in the hopes that the above-mentioned program will be instituted.

RECOMMENDATION: That the Quackery Committee function as an "on call" committee.

WILLIAM H. SAGE, M.D.

Quackery

Your Reference Committee next considered the report of the Quackery Committee. A full and complete discussion was held. Your Committee recommends approval of the report and its recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS

Your Public Relations Committee met monthly and during the year accomplished the creation, distribution and early analysis of our first Medical Opinion Survey.

Attempts were made during the year to reactivate the Speaker's Bureau. I'm afraid to date these activities have fallen flat.

We have considered, requested and recommended the incorporation of a professional public relations organization or representative into our Medical Society structure. To date the expense outweighs the budget allowances. We have gained the capable assistance of Mrs. Marilyn Wall who has acquired knowledge in advertising and public relations through personal sacrifice.

Community Health Week support has been obtained from the Governor by proclamation and was arranged to coincide with the Health Careers Day this year, Arrangements are hopefully being made for continued coordination of these projects. During the year we have had the pleasure of the presence of members of the Hospital Association, Pharmaceutical Association, Dental Association, and the Woman's Auxiliary. We hope to continue this.

We have reviewed the extramural and intramural functions of the Medical Association as closely as possible and have advised, both through channels and directly, methods of gaining the maximum coverage and mileage out of favorable actions.

I believe this has been a profitable year for the Association and, in general, a year of favorable public relations. With the advent of the questionnaire we should be able to improve our internal relations.

With my thanks and grateful appreciation to all the members of my committee.

BUDGET REQUEST:

7/1/71 thru 12/31/71	$2,000	PR Counsel
1/1/72 thru 12/31/72	$4,000	PR Counsel
	200	Hospitality/ Entertainment
TOTAL	$6,200	

RECOMMENDATION: That the committee be merged with the Public Relations Committee of the Honolulu County Medical Society and the HMA News Media Committee since most of the work and its members overlap into these committees.

ROWLIN L. LICHTER, M.D.

Public Relations

Your Reference Committee next considered the report of the Public Relations Committee. A full and complete discussion of the subject was held. Your Committee recommends deletion of the third to the last paragraph regarding arranging for press interviews with Dr. Payne. Your Committee further recommends that the word "society" in the second to the last paragraph be changed to read "Association." We recommend that the Recommendation be accepted. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. It was noted that the report of the committee does not contain a recommendation to hire a public relations counsel and therefore a motion was made to delete the budget request of the committee. The motion failed.

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLICATIONS

The Publications Committee undertook to review and evaluate all publication procedures, policies and business aspects of the Hawaii Medical Association. The committee's primary function was in an advisory capacity to the Editor of the HAWAII MEDICAL JOURNAL, therefore special reference was placed in the evaluation of matters directly concerning the JOURNAL.

The committee met four times during the year, and various members met informally on numerous other occasions. Mrs. Marilyn Wall was appointed as an Assistant Editor of the JOURNAL, primarily concerned with production and advertising. Her appointment resulted after reviewing a proposal for management of the JOURNAL by a local public relations and counseling firm. New JOURNAL advertising rates were formulated and instituted. This was done in an attempt to obliterate the previous year's deficit.

Major changes regarding the HAWAII MEDICAL JOURNAL were considered and approved as follows:

1. JOURNAL format was altered with a new and more appealing context.
2. Volume publication period to commence with the January-February issue yearly.
3. Associate and Assistant Editors appointed to aid the Editor in JOURNAL preparation.
4. A new section of review articles solicited from faculty members of the University of Hawaii.

The HAWAII MEDICAL JOURNAL continues to be a "labor of love" of the Editor and Publications Committee. We heartily endorse additional support from other members of the Association and would welcome editorial comments, articles, and suggestions for improvement. We believe the JOURNAL is a unique asset to our Association, and to the practice of medicine in the State of Hawaii. We want it to be your JOURNAL, and would welcome any help you can give us in that direction.

BUDGET REQUEST:

Format revisions $300.00

RECOMMENDATIONS:

1. That the Hawaii Medical Association continue to support the publication of the HAWAII MEDICAL JOURNAL.
2. That the committee endeavor to produce a new roster.
3. That the Hawaii Medical Association underwrite the cost of periodic JOURNAL and other publication revisions as to format and style.
4. That the subscription rate for the HAWAII MEDICAL JOURNAL be changed to $6.50 per year and to $1.50 per single issue, effective January, 1972, in anticipation of an increase in printing costs.
5. That Dr. Harry L. Arnold, Jr. continue as the Editor of the HAWAII MEDICAL JOURNAL.

MERYL H. HABER, M.D.
HARRY L. ARNOLD, JR., M.D., *Editor*

Publications

Your Reference Committee next considered the report of the Publications Committee. Your Committee recommends that the word "Society" in Recommendation No. 1 be changed to "Association." We further recommend that "as budgeted" be added to the end of Recommendation No. 3, and that Recommendation No. 4 be changed according to the Errata Sheet. We recommend approval of Recommendations No. 2 and 5. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC PROGRAM

The central theme chosen for the scientific program of the 115th Annual Meeting was "New Challenges to Chronic Disease." The speakers were selected for the program in June, 1970, and commitments were obtained by July, 1970. In addition to seven mainland speakers, two local speakers were asked to lecture to round out the program. The pattern of this year's program was modified so that physicians could attend one of three scientific lectures.

The Conference Center of the University of Hawaii College of Continuing Education and Community Service provided for a coordination of the program and made arrangements for all of the physical facilities. The Conference Center has been extremely helpful in assisting the committee in implementation of all of the various details such as printing of the program, provisions of audio-visual services, and administration of registration procedures. An estimated budget for the annual meeting was prepared by the Center and approved by the Council in September, 1970.

Grateful acknowledgment is made to the following organizations whose financial assistance made the program possible:

American Cancer Society, Hawaii Divison, Inc.
Bristol Laboratories
Burroughs Wellcome & Company, Inc.
Ciba Pharmaceutical Company
Geigy Pharmaceuticals
Hawaii Heart Association
Hawaii Thoracic Society
Eli Lilly and Company
Parke Davis & Company
G. D. Searle & Company
Smith Kline & French Laboratories
Schering Corporation
The Upjohn Company

Acknowledgment is also made to all of the Hawaii Medical Association members who have graciously accepted to appear on the program as speakers, moderators, and presiding officers.

The selected topic for the 1972 annual meeting is "Pathology as it Relates to Clinical Practice," which was approved by the Council in February, 1971. Planning of the program for this meeting has already started.

RECOMMENDATIONS: (1) That program planning for the 1972 theme of "Pathology as it Relates to Clinical Practice" be continued as early as possible. (2) That the committee continue to work closely with the Conference Center and utilize their expertise in convention planning.

ARNOLD W. SIEMSEN, M.D.

Scientific Program

Your Reference Committee next considered the report of the Scientific Program Committee. We recommend approval of the Recommendations and the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TELEVISION–RADIO

The members of this committee have continued to produce "Medically Speaking" on KHET-TV. With a change in the director of KHET-TV, there were changes in our relationship with the station and its personnel assigned to "Medically Speaking." Formal agreements were signed in KHET-TV to produce programs on specific dates, replacing the unwritten gentleman's agreement of undetermined duration. Funds were given to KHET-TV from which Mr. Gordon Burke's and Mr. Bert Darr's salaries were drawn. On one Wednesday evening a month, KHET-TV substituted "Medically Speaking" with another program. Assorted problems related to program planning, production, and directing were encountered and solved by forthright discussion and agreement.

Realities of TV program costs were brought to this committee's attention. For instance it was noted that a one-hour program like "Medically Speaking" costs $2,000 to produce, and that a 10-minute black and white, 16mm movie short done properly costs almost $100.

Recruiting doctors for neighbor islands to be panelists on "Medically Speaking" continued to be a problem. Lack of time to communicate and plan appeared to be the problem. Only one doctor from Maui appeared on "Medically Speaking." Programs on medicine and the community continued to be emphasized on "Medically Speaking," especially programs on the Drug Scene in Hawaii.

Radio Station KHVH was given assistance by this committee in a doctor discusses a disease show. Assistance was given in finding doctor speakers and subject matter of current interest.

The Messsage of the Month in differing formats continued to emanate through this committee. This was due to the untiring and thankless effort of Dr. William Moore.

BUDGET REQUEST AS ADOPTED:

July-December, 1971

Moderator @ $50 for 14 weeks	$ 700.00
Question Central @ $40 for 14 weeks	560.00
Sunday ads	220.00
Message of the Month	675.00
Refreshments (for panelists)	50.00
Transportation (neighbor island M.D.'s)	100.00
Visual aids (16mm shorts)	300.00
	$2,605.00

January-December, 1972

Moderator @ $50 for 32 weeks	$1,600.00
Question Central @ $40 for 32 weeks	1,280.00
Sunday ads	440.00
Message of the Month	1,250.00
Refreshments (for panelists)	100.00
Transportation (neighbor island M.D.'s)	200.00
Visual aids (16mm shorts)	700.00
	$5,570.00

RECOMMENDATIONS: (1) HMA continue the ads in the Sunday TV Guide for "Medically Speaking." (2) HMA continue the Message of the Month ad in the local papers. (3) Mr. Gordon Burke's salary be increased $10.00 per show, the first increase in four years. (4) That funds continue to be allocated for transportation and accommodations of neighbor island panelists for "Medically Speaking." (5) That additional funds be allocated for the production of occasional 16mm movie shorts for "Medically Speaking."

THEODORE T. TSEU, M.D.

Television-Radio

Your Reference Committee next considered the report of the TV-Radio Committee. Your Committee recommends accepting the budget request with the following amendments in computation: Moderator @ *$50* instead of *$40*, for a total of $700. Grand total for 1971 should be *$2,605.00* instead of *$1,930.00*. Budget request for January-December 1972; Moderator @ $50 for 32 weeks should read for a total of *$1,600.00* instead of *$1,700.00*, and for Question Central @ $40 for 32 weeks should read for a total of *$1,280.00* instead of *$1,360.00*, which brings the total budget for 1972 to $5,570.00.

Your Committee recommends adoption of Recommendations No. 1 through 5, and deletion of Recommendation No. 6.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY

The Committee met once this fiscal year with representatives from the Woman's Auxiliary to determine the future of "In Memoriam," the historical set of volumes containing biographical sketches of Hawaii's doctors from the early 1800's to the present time. These volumes were a gift from the Woman's Auxiliary to HMA at its centennial anniversary eighteen years ago. Since then, Mrs. Robert Katsuki has done a magnificent job in updating the volumes. However, Mrs. Katsuki is unable to continue this work and the Woman's Auxiliary found themselves in a predicament of finding a replacement or discontinuing this fine work. Since the volumes are HMA property, the Auxiliary asked the committee for advice. The committee wishes to thank the Woman's Auxiliary, and especially Mrs. Katsuki, who has given much devotion to this time-consuming but most worthy project.

RECOMMENDATION: (1) That this committee be merged with the Woman's Auxiliary Advisory Committee of the Honolulu County Medical Society so that coordination will be more effective, flexible, and useful in an advisory capacity from the parent body to its auxiliary.

EDWARD L. CHESNE, M.D.

Woman's Auxiliary

Your Reference Committee next considered the report of the Woman's Auxiliary Committee and recommends that Recommendation No. 1 be deleted. However, we suggest that the Woman's Auxiliary request specific funds for the "In Memoriam" project as required from the HMA Council. The Committee approves the second Recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. For further clarification, it was voted to amend Recommendation No. 2 as follows: be merged with the Woman's Auxiliary Advisory Committee of the Honolulu County Medical Society, subject to the approval of the HCMS, so that coordination. . . .

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT, WOMAN'S AUXILIARY

The Woman's Auxiliary is divided into 17 committees which assist the Hawaii Medical Association in their programs. These programs have led us into some exciting and unique projects.

The AMA-ERF committee reports over 500 in attendance at the "Kalabash" held March 27. The silent auction of handmade, homebaked, and homegrown items brought in $6,862.95. The program was excellent. Proceeds of $5,103.94 will be sent to the University of Hawaii School of Medicine to be used for whatever the Dean feels necessary. Continuing projects include the sale of notepaper by Honolulu, Maui, and Hawaii Counties and individual donations by Kauai County; the sale of Christmas ornaments and other items, and the sale of chances to identify Auxiliary members by their baby pictures.

Our new Children and Youth committee began by going to the Governor's executive in charge of the White House Conference on Children and Youth to inquire what help we might give. We received no encouragement and felt a definite political aura surrounding appointments as representative, so we asked Dr. Louise Childs to attend the AMA special meeting in Washington, thus showing our interest.

Community Service has been a challenge with nine health-related projects receiving our attention. These were Diabetes Detection Drive, Safety-Poison Prevention, Health Careers Day, Rubella Immunization, Mobile Blood Bank, Hawaii Heart Association, Cancer Society, Tuberculosis Association and the Tumor Survey. Health education programs Auxiliary members engaged in were: a Symposium on Marriage, "Whither Marriage, Whether Marriage," the Honolulu County Guest Day program, a lecture on "Physical Fitness and Your Heart," driving the Cancer Cruiser to shopping centers and schools, and a talk from the National Safety Council via Hickam Air Force Base Safety educator on Defensive Driving. "Today's Health" magazine continues to be sent to the libraries of high schools and colleges in the State.

Two members of the Auxiliary were selected to help plan the annual Health Careers Day program held at the HIC. Three publications are published by our State Auxiliary pertaining to Health Careers. Kauai County conducted a training course for girls ages 16-18, in the Junior Auxiliary or Candy Stripers using National Auxiliary materials.

A total of 460 biographies are finished and 265 photographs have been used in the "In Memoriam" scrapbooks that are done by Mrs. Robert Katsuki and given to the HMA. On March 11 the Woman's Auxiliary Committee met and voted to continue the project because of its value to Hawaiiana, and it was recommended that these books be circulated more to draw attention to their tremendous historical value. A vote of thanks was extended to the Woman's Auxiliary and to Mrs. Katsuki and assistance was pledged in recruiting people interested to help with this ongoing project.

The outreach value of the International Health Activities Committee is beyond comprehension. Over 22,000 lbs. of items collected were sent to Saigon, "Project Concern," Queen's Hospital Family Planning Unit, Samoa, "Africare," Waikiki Drug Clinic, "Operation Handclasp," Sisters of Social Service in Taiwan, and the SDA Hospital in Taiwan. Items sent as follows: two dental chairs and dental equipment collected by the Dental Auxiliary at our request, I.V. solutions and set-ups, surgical and medical equipment, assorted medications, educational material including 12 Physicians Desk References, oral contraceptives, physiotherapy equipment, Ethicon resterilization service ($500.00 value), and vitamins. Several individual physicians carry on Doctor to Doctor contacts and Kauai County is a contributing member of "Project Hope."

The Legislative Committee has found it difficult to function much in this term so near the elections, but has urged members to be active in politics and vote intelligently after studying the issues. The information gained from the Workshop this year will be put to good use before our next elections. Kauai County distributed a pamphlet on "How to Win Elections."

Our Membership Chairman has the monumental job of encouraging participation of some nearly 700 women. Each county carries out projects to interest members in projects. In Honolulu County new members were invited to a potluck luncheon where hostesses told of the projects and goals of the Auxiliary.

The Mental Health Committee placed emphasis on our annual Guest Day where over 200 women from local clubs and organizations heard an excellent presentation on "Whither Marriage, Whether Marriage." As per tradition, Christmas gifts were distributed at the Waimano Home and the Hawaii State Hospital. Kauai Auxiliary members helped in the craft center of Mahelona Hospital for mentally disturbed, and one of the members acted as a guide to a school psychology class while they toured Mahelona.

During Poison Prevention Week our Safety and Disaster Committee, with the cooperation of Meadow Gold Dairy, printed and distributed 15,000 leaflets on poison control to public schools. We were also part of a national drive in poison prevention and poison prevention posters were reproduced on a side panel of our milk cartons. A poster contest was held in six Honolulu schools and winning entries were displayed at shopping centers.

The "Aloha" Chapter of the Woman's Auxiliary to the Student Medical Association has been very active since its beginning this year. The advisors from the State and Honolulu County boards have been effective in making this chapter independent and joined to us in spirit. The group includes wives of medical school students, interns and residents who elect their own executive committee chaired by Mrs. W. S. Klipper. We were happy to entertain the National President of WASAMA, Mrs. G. Edward Kappler from New York, who gave an enlightening talk to the Auxiliary Board. The three-fold program outlined for the chapter this year includes: (1) Social activities such as a wine-tasting party, tour of Chinatown, and "Hawaiiana" lecture. (2) Aloha service for newcomers which includes a packette of helpful hints of things to do on "a shoestring." (3) Babysitting arrangements are planned to enable WASAMA women to become active in Auxiliary projects.

Our publication, "RX for Doctor's Wives," was distributed four times during the year and provided excellent coverage of all activities. There are three associate editors who managed the publication in spite of rising printing costs.

The Historian works with the Publicity Chairman and records all written material in a scrapbook. Excellent coverage by the media is often available.

It is indeed a privilege to have a National Auxiliary Board member in Hawaii and we appreciate her able assistance. We also have one of the Regional Chairmen in the International Health field on our board.

This is a factual report, and the very real friendships and joys of service that I have experienced far surpassed any and all facts. I would like to express my appreciation to the HMA for including the Auxiliary on many of its committees and the Council.

RECOMMENDATION: That all of the chairmen in the Auxiliary structure be invited to sit on the corresponding HMA committees whenever possible.

MRS. HAROLD G. LAWSON

Woman's Auxiliary President

Your Reference Committee next considered the report of the Woman's Auxiliary President. Your Committee recommends that the last sentence of Recommendation No. 1 be omitted, and that the entire second recommendation be omitted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

Resolution No. 1

Your Reference Committee then considered this Resolution regarding publication of an article on "Changing Concepts of Death" by Dr. John Lowrey. Your Committee fully concurs with the intent of this Resolution and recommends approval.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 1 AS ADOPTED

Re: Publication of Article on "Changing Concepts of Death"

WHEREAS, our retiring President, Doctor John J. Lowrey, delivered a paper entitled "Changing Concepts of Death," on Monday, April 5, 1971, to the Social Science Association of Hawaii, and on the following day, the Honolulu Star-Bulletin carried the text of the address, and

WHEREAS, the material contained therein clearly and logically points to the matter of death with dignity which we should all thoughtfully consider, now therefore be it

Resolved, by the House of Delegates of the Hawaii Medical Association that they shall give approval for the reprinting of this very excellently and thoughtfully prepared address in the next issue of the HAWAII MEDICAL JOURNAL, and be it further

Resolved, that Doctor Lowrey be congratulated and commended by the House of Delegates of the Hawaii Medical Association for this excellent paper which deserves wide circulation.

Submitted by JOHN F. CHALMERS, M.D.

Resolution No. 4

Your Reference Committee next considered Resolution No. 4 which relates to HMA membership for qualified osteopathic physicians. A full and complete discussion of the subject was held. Your Committee recommends that the first *Resolved* be deleted, and that the second *Resolved* be reworded as follows: "that this House of Delegates requests the HMA By-Laws and Parliamentary Committee to propose necessary By-Laws changes to allow membership in HMA and to propose qualifications for membership by osteopathic physicians. These proposals to be brought before the next House of Delegates meeting for consideration." Your Committee recommends approval of this Resolution as amended.

ACTION:

The Chairman recommended that this resolution be adopted. There were objections. It was moved and seconded that the second Resolved read as follows: Resolved, That the House of Delegates request the Hawaii Medical Association to study the problem of osteopathy and make recommendations at the next meeting of the House of Delegates." The motion was defeated.

It was moved and seconded that the second Resolved read: "Resolved, that this House of Delegates request the HMA to propose the necessary changes to allow membership in HMA and to propose qualifications for membership by osteopathic physicians, these proposals to be brought before the next House of Delegates meeting for consideration." The motion was carried.

The Chairman recommended that the resolution be adopted as amended. It was adopted.

RESOLUTION NO. 4 AS ADOPTED

Re: HMA Membership for Qualified Osteopathic Physicians

WHEREAS, the Hawaii Medical Association Bylaws and Parliamentary Committee has recommended no Bylaws changes to the 1971 House of Delegates, and

WHEREAS, Hawaii Medical Association membership is now compulsory for members of its component county medical societies and limited to doctors of medicine, and

WHEREAS, county medical societies are prohibited from making rules and regulations in conflict with HMA Bylaws, and

WHEREAS, the American Medical Association has shown leadership by amending its Bylaws to permit qualified osteopathic physicians to become eligible for AMA membership, and

WHEREAS, the HMA should likewise show leadership in the State of Hawaii by permitting qualified osteopathic physicians to become eligible for membership in the local and state medical societies, now therefore be it

Resolved, that this House of Delegates request the HMA to propose the necessary changes to allow membership in HMA and to propose qualifications for membership by osteopathic physicians, these proposals to be brought before the next House of Delegates meeting for consideration.

Submitted by MAUI COUNTY MEDICAL SOCIETY

ACTION:

The Chairman moved adoption of this report as a whole. It was adopted.

NOMINATING

The Nominating Committee met and submitted to the Council at its January 25 meeting the following slate of nominees to be elected by the House of Delegates:

President-elect	William E. Iaconetti
Treasurer	Thomas P. Frissell
AMA Delegate	George H. Mills
Alternate AMA Delegate	Theodore T. Tomita
Councillor from Oahu	William W. L. Dang
Councillor from Kauai	Peter Kim

All nominees have been contacted and have agreed to serve if elected.

WILLIAM W. L. DANG, M.D.

A letter of resignation from Richard D. Moore, Councillor from Oahu, was accepted, and the President asked for nominations from the floor to complete the two-year term of Dr. Moore. Drs. H. William Goebert, Jr. and Henry Yokoyama were nominated from the floor. Dr. Goebert was elected.

The President asked for nominations from the floor for President-elect, Treasurer, AMA Delegate, Alternate AMA Delegate, Councillor from Oahu, and Councillor from Kauai. No further nominations were offered. All nominations were closed and the Secretary was asked to cast a unanimous vote.

Having been elected President-elect, Dr. William Iaconetti resigned as Councillor from Maui. Dr. Sakae Uehara was nominated to fill the two-year term. The Secretary was asked to cast a unanimous ballot.

Nominations were sought for the Nominating Committee. The following were nominated: Ann Catts, Albert Chun-Hoon, William Dang, Winfred Lee, John Lowrey, Michael Okihiro, Niall Scully, Livingston Wong, Sakae Uehara, George Bracher, and Kenneth Fujii.

The results of the election were announced as follows:

President-elect	William E. Iaconetti
Treasurer	Thomas P. Frissell
AMA Delegate	George H. Mills
Alternate AMA Delegate	Theodore T. Tomita
Councillor from Oahu	William W. L. Dang

Councillor from Oahu (two-years).....H. William Goebert, Jr.
Councillor from Kauai.....Peter Kim
Councillor from Maui (two-years).....Sakae Uehara

Nominating Committee.....
- Ann B. Catts
- William W. L. Dang
- Winfred Y. Lee
- John J. Lowrey
- Livingston M. F. Wong
- George Bracher (Hawaii)
- Kenneth Fujii (Kauai)
- Sakae Uehara (Maui)

NEW BUSINESS

RESIGNATION

Dr. Sloan noted that Mrs. Heather Akana who has been responsible for the organization of the annual meeting will resign from the Association in May.

ACTION:

Dr. Sloan thanked Mrs. Akana for the work she has done for the Association and asked the House to join in a round of applause for her.

PRESIDENT

The work of the President was noted.

ACTION:

It was voted that Dr. John J. Lowrey be given a vote of thanks.

The meeting adjourned at 5:00 P.M.

R. VARIAN SLOAN, M.D.
Secretary

Call Us for
OPHTHALMIC INSTRUMENTS

OPTICAL DISPENSERS
of Hawaii, Inc.

532 PROFESSIONAL CENTER BLDG.
1481 SO. KING STREET — 955-6314

1133 BISHOP STREET
HONOLULU, HAWAII — 537-6570

1441 KAPIOLANI BLVD., SUITE 312
HONOLULU, HAWAII — 949-4795

103 PROFESSIONAL CENTER BLDG.
30 AULIKE STREET
KAILUA, HAWAII — 261-6030

Complete Contact Lens Service Available

Equipment Distributors for:

CARL ZEISS, INC., BAUSCH & LOMB, AMERICAN OPTICAL CO., SHURON, TITMUS, RELIANCE, WELCH ALLYN, KEELER AND LAWTON INSTRUMENTS.

County Society News

Hawaii

Twelve members were present at the May 20 meeting. Mr. Val Marciel of the Diabetic Survey gave the diabetic statistics for the year 1970. Speakers following were Mrs. E. DeCristofaro, Mrs. Mulder, Director of Planned Parenthood and Mr. James Hauser of the Health Education and Welfare Department who spoke of matters concerning the family planning efforts being made in the Hilo area. The cooperation of physicians in this community was requested.

Dr. David Woo, Hawaii delegate, reported on the recent Medical Association Meeting in Honolulu.

A motion was made to change the Bylaws for Articles —Chapter III, Section 4(c), Chapter IV Section 2(b) and Chapter IV, Section 3(b). This change in the Bylaws was voted to be approved by the members present.

It was decided that the funds for scholarship be granted as a loan rather than as a scholarship gift. The details regarding interest and requisites are being worked out by the scholarship committee. Dr. James Mitchel asked that some money be diverted to the scholarship fund.

* * *

The June 17 meeting was held at the Hilo Hotel with 10 members present.

Guest speaker, Dr. N. Kominami, gave an extremely interesting lecture regarding analgesic nephropathy.

A vote was taken to endorse the position of Mr. Keifer, Hospital Administrator, that a nurses' training facility be established on this island. This program would have to be an accredited program which would produce registered nurses with proper credentials and experience in order to have the Medical Society's full support. The proposed educational unit for nurses' training would be the Hilo Community College.

Maui

The May 20 meeting at Heinz Restaurant was attended by 24 members.

Following dinner, Dr. Neil Barrett spoke on drug interactions of the numerous drugs that are now available.

Correction of the minutes of April 20 are as follows: "possible malpractice cases arising with the Argonaut

continued page 353

Slants and Angles *continued from 282*

or unless existing services are radically reorganized, the burden of caring for ill, old people in the phase of pre-death will increasingly fall upon their elderly spouses, middle-aged daughters, neighbours, and friends." "The signposts to the future can be clearly read. The burden of illness in old age is due not to irresponsibility of relatives but to an enormous growth in need, requiring equally large redisposition of resources if our hospital and community services are not to be overwhelmed."

W. PHILIP JONES, M.D.

Inside HMA *continued from 281*

One example: Isn't it time that the people and the legislature were told that the greatest single factor driving up medical costs is the ridiculous malpractice situation? Not only do fees have to be raised to cover soaring malpractice insurance costs, but doctors feel a compelling urge to overdiagnose and overtreat in order to protect themselves. A law similar to the one Alaska passed recently, reducing res ipsi loquitur to realistic levels would serve everyone in Hawaii well. What are we going to do about the malpractice problem? Continue to turn our backs on it? Shouldn't we have some firm goals in this direction? There are many other problems facing HMA and the medical profession. Shouldn't we be facing them squarely?

I, a loud proponent of reducing the number of committees, hereby propose that we add one—temporarily—an Ad Hoc Committee on Goals. Let's give it six months of life, then let it expire. How about it, Herb?

JOHN BROWN, M.D.

In Memoriam *continued from 283*

tice, however, until the end of 1946, when he left Honolulu to make his home in South Pasadena, California.

He was for many years a member of the executive committee of the Honolulu Chapter of the National Foundation for Infantile Paralysis. He also gave many years of surgical work to Leahi Home and to Kalihi Receiving Hospital. On July 7, 1947, he was given recognition for the aid and support given as a medical advisory board member for selective service by both President Roosevelt and President Truman.

Dr. Craig died September 24, 1949, at Los Angeles at the age of 54.

He was a Fellow of the American Medical Association, Fellow of the American College of Surgeons, a diplomate of the Board of Orthopedic Surgery, American Academy of Surgeons, Territorial Medical Association (president 1941) and the Honolulu Medical Society (president in 1933 and elected to honorary membership in 1947).

MRS. A. L. CRAIG

Value lives! Our coupon proves it.

Learn about the Unitest System. Yours for less than $600. And with performance that lets your assistant run any of 16 blood tests routinely—including Blood Glucose, Hemoglobin, B.U.N., Uric Acid, and Cholesterol.
The Unitest System is easy to learn. Easy to use. Compact and highly accurate. It's totally designed for your convenience—giving you test results in your office, often before the patient leaves.
The Unitest System. You'll find it an excellent investment—at a very reasonable price.



Bio-Dynamics, Inc.
9115 Hague Road
Indianapolis, Indiana 46250
The Simplifiers

Bio-Dynamics, Inc., Dept. H 771,
9115 Hague Road,
Indianapolis, Indiana 46250

Please send your Unitest System brochure . . . the one that shows how much value I can get for less than $600.

Name
Specialty
Address
City
State
Zip

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: NOEL D. EVANS, *Vice President:* EDMUND E. EHLKE, *Secretary:* LAUREN WONG, *Treasurer:* MARION LOO, *Past President:* BETTY BELL, *Directors:* NELLIE CHANG, WALTER HIRANAKA, JAMES MCELHANEY, EARLE SANDISON, HON TING CHEE, BEN CHOCK, ROY NAITO and WILFRED OGOMORI.

The President's Corner

PRESIDENT'S REPORT—1970-71

Given at General Membership Meeting, June 23, 1971.

I would like to thank you for giving me the opportunity to serve our profession as President of the Hawaii State Pharmaceutical Association. You gave me an active, professionally dedicated Board of Directors and Officers, and together I hope we fulfilled some of your expectations.

A brief overview of the year's highlights follows. May this year be used as a building block for the years to come. The Hawaii Pharmacists' Bulletin published in conjunction with the HAWAII MEDICAL JOURNAL provides our membership with pertinent information of value to both disciplines of pharmacy and medicine with the additional opportunity to broaden common areas of understanding and cooperation. I recommend that an interim single sheet newsletter be considered for the membership in between JOURNAL publications in order to keep the membership up to date on matters requiring immediate action. (Ex.—HMSA—title XIX—dilemma)—recent BNDD rulings legislation.

My thanks to Karl Miller and Noel Evans for a good Seminar last September by the University of Utah School of Pharmacy—another in January 1971 in cooperation with Dr. Ronald Pion and U. of H. School of Public Health on family planning.

The annual H.Ph.A. Convention chaired by Omel Turk in conjunction with the Post. A.Ph.A. convention in San Francisco provided an additional learning experience for our membership in the areas of cancer chemotherapy and family planning.

Henry Urashima, program chairman, has provided us with outstanding quarterly meetings starring such notables as Honolulu Police Chief Keala, Dr. George Mills and, this evening, Mr. Jerry Estavillo and Mr. Akeo. Ray Naito, with the capable assistance of Jane Tarawasa and Noel Evans, posted a membership of 161 pharmacists and 40 associate members.

Our Legislative Committee with Glenn Pang, Omel Turk, Wilfred Ogomori, and others truly interested in our professional future donated endless hours to accomplish the passage of Act 131 relating to the Qualifications for Licensure as a Pharmacist. In addition, we supported many other bills including the Hart Bill supporting a stronger, more comprehensive Statewide Drug Abuse Program, etc. We opposed State purchasing of Drugs by Generic Name and FDA Policy Statement on Combination Drugs. This committee also circulated a questionnaire on licensure. Countless member comments relative to the total lack of appropriate statutes to protect the public health in the interest of he availability of professional pharmaceutical services were heard. I recommend that (1) Adequate statutes be developed by this Association to equate the professional practice of pharmacy in Hawaii with that of the other 49 States. (2) To include controlled licensure of successful national Board examinees, with continued-educational participation requirements for renewal. (3) We must increase the number of pharmacists from 29/100,000 to at least 45/100,000; National or 65/100,000. (4) We request immediate regulations from the Board of Pharmacy to develop the pharmacist potential made possible by Act 131. (5) We request re-codification by the Attorney General and subsequent publication of all laws pertaining to the practice of pharmacy for distribution to all pharmacists in the State via the Board of Pharmacy.

Several new committees have been structured this year—perhaps the most significant has been the HMSA—Peer Review Committee chaired by Hon Ting Chee. The Association, thru this committee, is fighting for proper reimbursement of pharmacists in third party contracts—Medicaid. We will need your help to develop annual cost data. Answer the call. Don't wait for that disinterested actuarial expert to tell you how much it cost to run your business and how much you will receive for services. Let's control our own destiny!!

The new Aloha Committee was chaired by Conchita Conchero. If we knew of an important event in your life, you were acknowledged. She and her committee greeted visiting dignitaries, and in general, shared the warmth and aloha of our islands. T. Torigoe and Richard Hori researched opportunity to stretch our dollars as members of our Finance and Investment Council.

As mandated by the Board of Directors preceding my term, we arranged for the acquisition of the Meyer Collection of Hawaiian Pharmaceutical Artifacts and presented it to the Bishop Museum. Mr. August Meyer became Hawaii's member to the American Institute of the History of Pharmacy. We also activated the Ethics committee via guidelines established for self-determination and solution of grievances against our colleagues.

You were ably represented on the Health Facilities Planning Council by Karl Miller, "Chec" by Earl Sandison, James McElhaney, Ed Ehlke and Lauren Wong, "Career Day" in cooperation with the HMA. Scholarships were capably researched by W. McPherson and the Awards Committee capably chaired by Jane Tarawasa.

Additional interprofessional relations achievements were gained via our 15th Annual DDD Golf Tournament directed by Walter Murakami, Richard Yoshino, and Albert Chang, the tireless efforts of James McElhaney and his Drug Abuse Committee, and via the distribution of "poison kits" during National Poison Prevention Week by Clarence Yee and his Poison Control Committee. Our thanks to McKesson for their assistance in the distribution of the kits to the pharmacies, the press, radio, and TV for their coverage.

The hospital pharmacists, represented by Florence Frick, and the Retail practitioners by Sidney Kosasa, cooperated with all chairmen in their respective areas of service. Alice Yee worked diligently to present you with a fine slate of officers. Mrs. Gwen Baer was engaged and has served well as a part-time executive secretary. She will be forwarding a pharmacy directory to you shortly which will be continuously updated as changes are received. Our collective thanks to Walter Hironaka for allowing the Association a phone listing in conjunction with his Kailua pharmacy. We had a



Omel Turk is presented the A. H. Robins Bowl of Hygeia award by Jimmy Asato.



Henry Urashima presenting the E. R. Squibb award to Miss Betty Bell.

listed contact for the first time.

The faithful attention and attendance of Nolan Hasegawa and Richard Hori, our Secretary and Treasurer, and certainly Noel Evans, V.P., have made the business functions of my year a pleasure. Ed Ehlke deserves a special bouquet for establishing the Non-Profit tax status of this Association—a fact we had thought already secured. To those good souls, Thor Engwell, Nellie Chang, Noel Evans, Bob Craft and others who provided material for the Bulletin, Mahalo.

Our professional image is but the lengthening shadow of men. The men and women I've mentioned and the many, many more that I haven't. There is no question that this will be a fiercely competitive and changing decade . . . errors in our judgment *now* relative to the practice of our Art will carry the highest price tag in the history of our professional existence. I remember the advent of the "big discount store," supermarket, the big chain, and the panorama of fear we evpressed, *but* they were a grain of sand in the desert in relation to *"Big Brother"—Government*. Pharmacy, 1971 is at the crossroads. An exciting new world awaits the opportunity to restore our proper heritage. It's past time we assumed our rightful place as members of the health care team via the pharmacist's personal involvement in a meaningful patient care situation.

One doesn't stand still in an expanding economy; you move ahead or slip back. Which will it be for pharmacy? In effect, we're all on one big payroll. One facet of our profession cannot be ill for long before it effects us all. (Already we're seeing changes in the health care delivery system such as the development of Health Maintenance organizations, Health Care Corp., Medi Credit, etc.) We must recognize our responsibility as an association to develop a climate in which we can *all* operate successfully.

Analyze yourself in terms of your contribution to the over-all good of our profession. Personal contributions of your time and talent should be considered a tax due to Noel Evans and your association officers to keep your professional economy of vibrancy and continued growth in balance.

Thank you for your attention and your consideration. I'm serving you with your Tax Bill tonight, payable in service to this Association and the officers you have elected.

BETTY J. BELL

QUARTERLY DINNER MEETING: JUNE 23, 1971, FLAMINGO CHUCK WAGON

Guest Speaker: Mr. Jerry Estavillo, State Investigations and Narcotic Control System. Special Guests: Mr. Carl Tomimitsu, Food & Drug Administration; Mr. Richard King, Pharmacy Consultant ATW, San Francisco, California. Master of Ceremonies: Mr. Herman Wat.

Miss Betty June Bell, outgoing president, opened the meeting with her annual report.

The E. R. Squibb Award was presented by Henry Urashima to the outgoing President, Betty J. Bell, in recognition of her services to pharmacy during the past year. Miss Bell is the first woman to receive the award in the history of the association. Roger Thompson presented the McKesson and Robbins award to the incoming President, Noel Evans, as a symbol of his authority for the coming year.

The A. H. Robins Company "Bowl of Hygeia" award, for appreciation of time and personal sacrifice to the welfare of the community, was presented to Omel Turk by James Asato.

Noel Evans presented the Pharmacist of the Year award to Betty J. Bell for her contribution of time and service in the interest of Public Health through the profession of Pharmacy.

Newly installed officers for the year of July, 1971 to June of 1972 are: President Noel D. Evans, Vice President Ed Ehlke, Secretary Lauren Wong, Treasurer Marion Loo, Board Directors Nellie Chang, Walter Hiranaka, James McElhaney and Earl Sandison. Board members returning for another year are: Hon Ting Chee, Ben Chock, Wilfred Ogomori and Roy Naito.

Noel Evans outlined some of the events for the coming year: Educational seminar in September, efforts for favorable legislation for pharmacy, and continued work for a satisfactory payment schedule for third party prescription payments.

New pharmacists who had recently passed the Hawaii Board Examinations were introduced. They were: Larry Bridges, Tripler General Hospital; David Cook, Longs —Ala Moana; Richard Itami, Kauai General Hospital—Waimea; Joanne Martin, Wahiawa General Hospital; and Russell Piazza, the Honolulu Medical Group. Recent pharmacist arrivals to Hawaii were recognized: Carol Wolford, Thrifty Drugs in Hawaii Kai, and Al Ludwig, Wilcox Memorial Hospital in Lihue, Kauai.

We were extremely glad to see the large turnout of pharmacists from the outer islands: Harvey Wilhite—Hawaii, Jack Pawol—Maui, Robert Craft—Maui, Richard Itami, Al Ludwig & Betty Bell—Kauai.

Thanks for your support!!

Five scholarships were granted to Hawaii pharmacy students attending mainland schools of pharmacy. Those so honored were Jana Ellen Hong, University of Southern California; Yvonne Sur, University of Washington; Sandra Kau, University of the Pacific. Dianne Louise De Forest and Hong Suhk Kim will enter the University of the Pacific in September.

Special recognition was given to Miss Bell's mother, Mrs. Hazel Bell. Mr. Gale Rose. A new Lederle representative was introduced.

The meeting was adjourned with a reminder of the June 24, 1971 seminar for consultant pharmacists by the Department of Health.



Miss Betty Bell receiving the Pharmacist of the Year award from the HPA.



Noel Evans receiving the McKesson & Robbins award from Roger Thompson.

PHARMACIST OF THE YEAR

At the quarterly meeting of the Hawaii Pharmaceutical Association on June 23, Miss Betty June Bell was selected by her colleagues as "Pharmacist of the Year." This award is given annually to the pharmacist who has worked unceasingly in promoting public health through the profession of pharmacy. Miss Bell has unselfishly given much of her time in active pursuit of promoting pharmacy for the benefit of public welfare. For several years she has helped place the profession of pharmacy as a rightful member of the health team. We salute her for a job well done as President of the 1970-71 year, and for her past service as vice president and director. Not only is she a valued member of the HPA, but she is an associate member of the American College of Apothecaries, a member of the American Pharmaceutical Association, American Society of Hospital Pharmacists, and was chosen for WHO's WHO of American Women for 1970-71. Hawaii was very fortunate when she came to practice pharmacy here in March of 1966. Miss Bell is director of Pharmacy & Personal Services at G. N. Wilcox Memorial Hospital in Lihue, Kauai. She is also Assistant Administrator of the Hospital. At Wilcox Hospital, Miss Bell has established a complete unit-dose system of drug distribution, and has set up the pharmacy system in the outpatient clinic which filled nearly 74,000 prescriptions in the first year of operation. Every year, she has been instrumental in expanding pharmacy services in the hospital and community. Congratulations to our "Pharmacist of the Year," Miss Betty June Bell!

President's Message

Over the years, pharmacy has gained a meaningful place in the health care field. In Hawaii, we hope to strengthen that position by effective representation in Intraprofessional Relations committees and legislation of pharmacy matters in the interest of public welfare. The Hawaii Pharmaceutical Association is striving to gain its rightful place as a consulted member of the Hawaii Health Team.

This year, emphasis will be projected into pharmacy and public health legislation, drug abuse, educational seminars, and in obtaining a satisfactory third party prescription payment schedule.

Your ideas, thoughts, and suggestions are truly solicited. I hope each one of you will step forward with your help and support. Don't wait to be called; call any of your elected HPHA members, and let your views be known. The Association will only be as strong as the willingness of its members to serve.

By now, you all have received dues statements. We hope that those who have put the statement aside will soon send their checks in. Many feel the HPHA has a sound financial reserve, but if we do not have your continued support, that reserve could rapidly be reduced. Some may ask what the HPHA is doing for them; ask yourself your chance of standing alone! Legislation benefiting pharmacy looks very promising, but lawyers must be obtained to assure us of its legality. A tentative schedule of this year: Board meetings, the 2nd Thursday of each month, 7:30 P.M. at Kuakini Hospital, plus general membership meetings in September, January, April and June. In September, a three-day seminar by the College of Pharmacy, University of the Pacific, is planned. October will be VD Prevention Month with the HPHA as the sponsoring organization. Career's Day will be in February, Poison Week in March, the DDD Golf Tournament in April, either a convention or a seminar in May, and the installation of the 1972-73 officers in June of 1972.

Your support for pharmacy in Hawaii is greatly needed.

NOEL D. EVANS

Board of Directors Meeting

On June 10 the monthly meeting was held at Queen's Hospital. Those present were: B. Bell, N. Evans, E. Ehlke, R. Naito, J. Tarasawa, A. Yee, C. Cachero, K. Miller, G. Pang, W. McPherson, and N. Hasegawa.

Letters of acknowledgment were received from Representatives S. Matsunaga, P. Mink and Senators D. Inouye, H. Fong concerning the Food & Drug Administration Proposal 21 CFR Part 3—Combination Drugs for Human Use. Senator Inouye disagreed with the views of the APHA.

An invitation was received from the State Department of Health to attend a seminar on Consultant Pharmacists Service on June 24, 1971.

The Legislative Committee will present complete proposals for the next year.

Tax Status: Approved tax exemption status.

The appointment of Karl Miller to HMSA Peer Review Group Committee was announced.

A request was made to the Board of Pharmacy for regulations to accommodate Act 131.

The Board approved the idea of a VD prevention campaign. Such a campaign can be presented by Young Drugs free of charge.

President Bell thanked the Board for its cooperation and dedication and for giving her the opportunity to serve as President of the Hawaii Pharmaceutical Association.

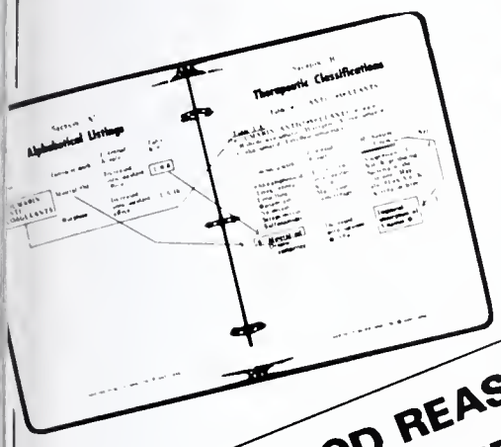
* * *

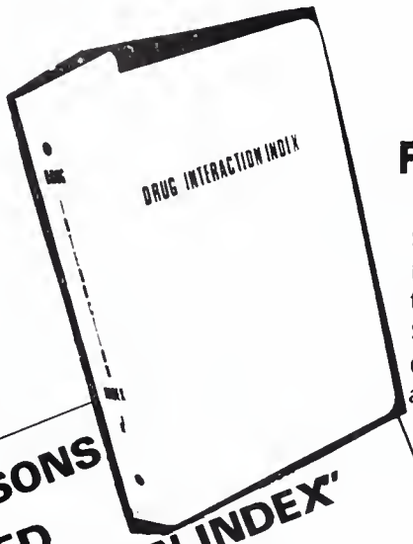
Eighteen members attended the July 9 meeting at Kuakini Hospital.

Pharmacy Board Chairman Richard Yoshino and G. Pang will work together on legislative matters. A conservative figure of $3,000.00 was suggested by N. Evans

continued page 354

NEW! DRUG INTERACTION INDEX





16 GOOD REASONS WHY YOU NEED "DRUG INTERACTION INDEX"

1. Over 300 listings of drugs by Generic name thus making Index applicable in Canada, USA and other countries.
2. All drugs are listed individually as are those drugs used in everyday practice.
3. Alphabetical listing gives quick finger tip reference.
4. Immediate and concise information as to possibility of an interaction and potential result.
5. Every drug cross-indexed at least three times.
6. Twenty-one (21) Therapeutic Tables with 62 Sub-classifications.
7. Therapeutic Classifications give further detail as to potential result.
8. Also describes mechanism of action, if known.
9. All listings and therapeutic classifications from documented sources (bibliographies included).
10. Explains and gives examples for most drug interactions.
11. Can be used to prevent possible drug interactions.
12. Can be used to aid in the diagnosis of possible drug-induced illness.
13. Designed so that Index can be easily and readily used while dispensing.
14. Readily adaptable to dispensing counter, library shelf, or doctor's bag.
15. Index to be updated with supplements.
16. Ring binder form permits ease of insertion and maintenance.

FOR PHARMACISTS & PHYSICIANS

SECTION "A"
Lists drugs alphabetically, making it easy to find the drugs in question.

SECTION "B"
Contains Therapeutic Classifications and serves as source of more detailed information when needed.

MECHANISMS OF ACTION

Recognizing the fact that Drug Interaction is a relatively new field and that many professional persons wishing to use the Index might find it difficult to draw a mental picture of some mechanisms of action, we have given an explanation for some Drug Interactions and examples of each one.

DISTINCTIVE FORMAT

Facilitates efficacy of Index — quickly indicates whether or not a drug already in use or about to be used is likely to react with other drugs or components of the diet.

FAST AND INFORMATIVE

We believe that the DRUG INTERACTION INDEX provides for the first time an ideally fast and informative guide for the busy pharmacist. To be sure, there will be times when further research and detail will be necessary, but for that quick, single, hour-to-hour, day-to-day reference, the DRUG INTERACTION INDEX will serve a very useful need.

ASSISTANCE TO PHARMACIST

While primarily intended as a guide, proper utilization of this Index will assist the pharmacist in advising not only how to take medication, but what or what not to take with it, and will thus lead to better patient care in the area of medication and will be an effective first line of defence against therapeutic misadventure.

Meditec Publications Ltd.
1635 Abbott St., Park Medical Building, Kelowna, B. C., Canada

Please send _____ copies of the Drug Interaction Index @ $20.00 per copy. Enclosed is my remittance in full totalling $_____.

Name_____

Address_____

City_____ State_____ Zip Code_____

(Applicable for use in USA — Canada and other Countries)

you see a golf ball come this way?" She dipped her spoon into her cauldron and brought out the lost ball. His zealous words of appreciation touched her witch's heart and she decided to grant him a wish. Searching his soul, he confessed his innermost desire, "I wish to be a scratch golfer." "In return, you have to give up something. Would you sacrifice your sex life?" she demanded. He thought for only a moment and agreed. He forthwith dropped the ball and took a swing. The ball sailed a high arc over the trees and landed smack next to the pin. He was ecstatic. In the days that followed, he could do no wrong and his handicap quickly dropped to zero. Several months later, the grateful golfer meandered into the same woods in search for the witch to thank her. "But how about your sex life?" she asked wonderingly. "Oh," he replied, "Only two or three times a month, but that's not bad for a priest in a small parish."

Elected, Appointed, Honored

We had picked up a news clipping mentioning that **Sam Allison** was elected to the board of the Bank of Hawaii, but Sam called us saying this was not so, although he wished it was so . . . Since we can't think of anyone more suited and qualified, we told him so . . .

Personable **Ed Colboy,** associate director of the Pacific Institute of Rehabilitative Medicine, was honored by Abilities Unlimited, Inc. Ed received the Kokua Award for "his untiring interest, concern and dissemination of information and education on rehabilitation and the physically handicapped."

Pediatrician **Cal Sia** was named to the National Advisory Council on Child Health for a four-year term. Our favorite Woman's Lib gal, **Cora Manayan,** was commissioned to serve on the State's Commission on the Status of Women. **George Schnack** received an award from Big Brothers of Hawaii. **Allan Leong** was named to the board of directors of Pacific Guardian Life Insurance Co., Ltd. and Hawaii Thrift & Loan Inc. **Andrew Ivy** was appointed to the board of the new service corporation, Island Financial Service Corp., a subsidiary of Island Federal Savings & Loan. **Cesar De Jesus** was elected to the board of the new Pacific Division of the American National Red Cross which will serve American possessions of the entire Pacific from Hawaii to the Trust Territory. **D. V. Reddy,** chairman of the children's heart screening program, was honored by the Hawaii Heart Association with a Bronze Service Recognition Medallion.

On Kauai, **Kenneth Fujii** was elected president of the Kapaa Golf Club and **Gonzalo Geroso,** with the Wilcox Memorial Hospital staff, became the first diplomate of the board in Hawaii of the American Board of Family Practice.

Herbert Nakata was elected chief of staff at Children's Hospital and **Ed Kagihara,** vice president, and **Ann Barbara Yee,** secretary. In accepting the post, Herbert promised to implement the 3 C's viz communication, cooperation, and charity, but above all charity. RMP director, **Masato Hasegawa,** was all agush about the recent appointment of our Alii, **George Mills,** to the newly organized Medicine Section of the prestigious National Institute of Sciences.

Thomas Cashman was elected to fellowship in the American Academy of Pediatrics and **James Ball** and **Melvin Levin** were granted fellowships in the 17,000 member American College of Physicians . . .

Hors de Combat

Our cavalier RMP director-pediatrician-polo player extraordinary, **Masato Hasegawa,** once refused to mate his precious Irish Wolfhound with the only other member of its species in Hawaii because he wasn't sure she had the proper credentials. About eight months ago, the unmated wolfhound passed on to dog heaven probably with a broken dog heart. Our distraught dog fancier quickly acquired another, even before the respectable time of mourning had lapsed. Now the fragile new wolfhound, all of 150 lbs. of him, sleeps in the master's bedroom while Asako, Masato's healthier wife, sleeps in a separate bedroom. Greater love hath no man for a poor animal . . .

We always suspected **James Nishi** of a Midas touch . . . Jim owns stock in Pinkerton's Inc., the famous detective agency. In June, he received a routine dividend check through the mail which was supposed to be for $3.13, but the supersleuth agency's errant computer had generously made the check for $22,222,223.13. Rather than cash the dividend check, Jim plans to mount it . . .

Jim has a talented son, Steve, a third grader who is a touring concert pianist in his own right. Steve recently got paid a trifling $100 for one of the best TV commercials we have ever viewed in which he sings the Sunkist commercial, accompanies himself on the piano, and bows at the end with a toothy, ear-to-ear smile. When Steve decided to donate the entire proceeds to the Honolulu Symphony, Jim happily matched the sum which was turned over to Maestro La Marchina.

There is an apparent rash of thefts on Kauai. Recently **William Ciancio** and his wife, visiting from Honolulu, parked at the Russian Fort to study the ruins. On returning, they discovered their car window had been smashed and $94.00 taken from his wife's purse and his wallet. An expensive way to view a pile of rocks, we must say . . .

Sportsmen

Racketeers

Excerpt from Rock Rothrock's article on the Hawaii State Open Tennis Championships: "There was one lighter moment. **Sharon Bintliff,** the tennis playing pediatrician who was a junior golf champion in her native Texas, chastised the crowd in her match with Miss Young. 'Don't you ever applaud a good shot?' she asked the gallery after being passed for the umpteenth time. So she applauded alone." (That's our Sharon.)

Those Kaiser boys swing a mean racket. In February, **Alex Roth** and **T. K. Lin** won the men's doubles crown of the Kaiser Permanente Medical Group Tennis Championship by defeating **Hau Vu** and **Jim Bennet. Victor Dizon** and **Stanley Tanaka** finished third.

Duffers.

John Morris and his partner were described as "two of the best ringers, sand-baggers and handicap specialists in the business" when they won the 54-hole 5th annual Kokua Klassic golf tournament at Kaanapali, Maui, in May.

It is the gospel truth that golfer **Sam Yee** is being credited for former Islander Chuck Vinson's improved batting from a 0 to 16 start to a 14 for 30. Sam simply gave Chuck a golf tip, "Don't look up too fast."

The first annual Kuakini Staff Golf Tournament was held at Mid Pac CC in June with 40 participants. **Naomitsu Tajima,** who had a hot putter all day, won overall low net and the jackpot with a net 70, even after getting the tournament jitters and 4 putting on the last hole. Our happy generous winner hosted the entire dinner group to a round of champagne and took home a TV set. In a third place tie were **Masaru Koike** and **Frank Fukunaga** with net 72's. **Cool Wakai** won the first nine jackpot with a *33½*?

Fishermen

We nearly missed this important item from last October: "Doctors catch boatful." It seems that **Tom Frissel, Ted Tsen, Hunky Chun,** et al went fishing over a weekend on the Kuu Huapala and returned with two

marlin, nine mahimahi, and bait-tank full of akule. Hunky's marlin weighed 190 pounds and Tom's 138. In April, **Tom Frissel,** with a new crew, again boarded the Kuu Huapala for a three-day weekend trip off Molokai and returned with 18 mahimahi, several big opakapaka, a white ulua, and a huge oio.

Phil Corboy, fishing with the Hawaii Big Game Fishing Club, was a member of the three-man Hawaii team of light tackle experts entered in the Classic International Light Tackle Billfish Tourney held off Baja, California. Phil bagged three bill fish with 20 lb. test line.

Bruce Carter, writing in his column, "Fishing," reminds us that **Richard Sakimoto** holds the 30-pound test line record for Rainbow Runners with a beauty that went 25 lbs., 12 oz. In May, Dick, **Ed Ichiriu,** et al went overnite bottom fishing at the Banks and filled the iceboxes with uku and an assortment of Kahala, opakapaka, and beautiful red fish.

Yachtsmen

In February, **Mel Levin** steered the Santana 27 Calypso in its first win. Again in April, Mel Levin and **Elmars Bitte** sailed their Calypso in a Class B win. In June, with eight ships entered, **Les Vasconcellos** sailed his Wailele Maru in the 5th annual Harold G. Dillingham Race.

Physicians Speak Up

Richard You, Olympic official and "the Honolulu medic afflicted with postcarditis" (according to Ed Sherman) writes: "Here I am in Czechoslovakia, where the weather is beautiful and so are the hot pants and mini skirts."

When a book making City Hall official got away with a minimal fine, **Mary Glover** wrote in righteous indignation from Waianae: "No wonder there are protesters of the Establishment—and we are about to join them—when a systems analyst in our City Hall is arrested and pleads guilty to charges of running a gambling operation with links to organized crime and gets fined a slap-on-the-wrist $100. If we wonder where juvenile delinquents get their models we don't have to look beyond City Hall these days."

Marie Faus, a pioneer in family planning, ran one of the first clinics at Palama Settlement many, many years ago. She remembers how the pulpits of most churches roundly condemned the clinic when it was first begun. "There was one priest, though, who said just as many nasty things about the clinic as anybody else, but he was careful to repeat the address of this dreadful place three times."

TIME, March 31, covers the report by psychiatrists **John McDermott** and **Walter Char** at a meeting of the American Psychiatric Association on nurses in Honolulu hospitals suffering "acute identity crises" or doubts about their roles in aiding abortions. "They saw the abortion patients as promiscuous, brazen women who should be punished for their misbehavior rather than as women in the midst of crisis—agonized, afraid, needing support and counsel." During group sessions with the nurses, it seems that one nurse, critical of her patients' sexual permissiveness, made a frank confession: "I guess I'm jealous that they're having so much fun."

Maui's **Robert Moser,** former Chief of Medicine at Walter Reed, reported at a symposium at Memorial Hospital Medical Center of Long Beach that adverse reactions to prescription drugs were increasing. Bob warns that "There's a kind of 'domino' effect becoming more common, in which the patient has a bad reaction to drugs used to combat the initial reaction. About 3.6% of all patients admitted to Johns Hopkins University Hospital during a recent study period suffered adverse drug reactions, and 4% of all patients were specifically admitted for treatment of drug reactions . . .

continued page 342

ACCUTRON CENTER

ACCUTRON "MD"



Doctor, this watch was made for you!

ACCUTRON makes an electronic watch for everyone, and the "MD" was created just for doctors.

Water-resistant, 14k gold case. Sweep second hand, date, applied gilt stick silver dial. 20 seconds printed pulse reading figures from 60 to 110, with caduceus emblem at six. Rust allegator strap.

$225

There's only one Accutron by Bulova, the watch that's guaranteed accurate to within a minute a month.* But there are many different models and styles. We've got nearly a hundred of them. As a matter of fact, we have every Accutron model produced by Bulova today. From $110.

*We will adjust to this tolerance, if necessary. Guarantee is for one year.

USE OUR CHARGE PLAN
OR ANY MAJOR CREDIT CARD

SECURITY DIAMOND CONRAD JEWELERS

HAWAII'S LEADING JEWELERS FOR OVER A THIRD OF A CENTURY
ALA MOANA CENTER

About 30% of patients under treatment for reactions then suffered reactions to drugs used to treat them."

Eloquent Willis Butler is critical of Harry Bridges who apparently said, "The ecologists are 'anti-people' ... the ecologists' logic demands a reversion to primitive stages of human existence ..." Willis says, "Know-nothings are not new and the labor movement has had its share of them. As H. G. Wells remarked, the last dinosaur probably thought he was muddling through pretty well."

Dermatologist **Norman Goldstein** described in CUTIS that 'PreSun,' a new commercial sunscreening lotion, was "pretty close to a miracle." Its effectiveness as a sunburn protective was rated excellent to good in over 95% of patients with rare and minimal bad reactions. Norman says, "Back in training in New York, he had been told that orientals never developed skin cancer, but he has learned that all people are susceptible, even the darkly pigmented native Hawaiians."

Our crusading pathologist, **Paul Tamura,** was one of five people testifying at a City Council public hearing for proposed pay raises for the mayor and municipal department heads. Paul, however, was testifying for increased pay for the City medical examiners office and said, "This is a highly specialized job. Forensic pathologists are hard to come by. The present salary is way below that a man with this training could make elsewhere."

Harry Shirkey, who left to chair the Dept. of Pediatrics at Tulane, is a member of the AMA Council of Drugs which compiled the AMA's "Drug Evaluations 1971" at a cost of $3 million. Harry says, "A number of practicing physicians have said it's nice to have somebody working for us and our patients without any ax to grind. It's not like something that's in the 'Physicians' Desk Reference' or oriented by a pharmaceutical company."

A Sam Pryor (a graduate of the US Treasury Narcotics Agency School) held an educational seminar in which he branded marijuana a very dangerous drug. **James Erickson,** an equally vociferous supporter of liberalized marijuana laws (who has seen over 6,000 people who have smoked marijuana during his 10 years of practice and has studied their habits) was critical: "What really is happening is that like many members of the older generation, Mr. Pryor is stricken by irrational fear of the new generation's freedom and disregard for rigid structures of the old social order. I don't advise anyone to smoke marijuana, but I am less afraid of it than I am of tobacco, alcohol, and puritanic repressive thinkings."

The Honolulu Police Commission clamped a muzzle on police officers who were critical of recent transfers within the Police Dept. Chairman **Bob Chung** had suggested that "public derogatory comments on the official action of a superior officer" be added to the list of actions which constitute conduct unbecoming a police officer. Bob maintains toughly: "It is in no way an abridgement of freedom of speech," and likens a policeman "to an army buck private who questions his orders."

A Hamilton Anderson adjoins: "May I join with all others who seek a more balanced environment for our children and grandchildren than we have endured ... We have built an industrial empire without a toilet! In a word, we are now living in an affluent world with its accompanying effluents wherever modern technology has held sway in the name of progress ... This was the way of life in Old China where the hutungs (small streets) of the wealthy and poor alike were dumping grounds for their garbage at their own gates ... Developers of today's Asiatic carbon-copy of our own technology have permitted the invasion of their own countryside with all technologic wastes to cloud their own superb attractions — notably Fuji, now shrouded in mourning ..."

Rebuttal

Physicians as a group are forever subject to attacks by the disgruntled ... A Bette M. Gerstacker writes in a letter to the editor: "I am appalled at the manner in which many doctors run their practices today. It seems the basic concern in most cases is getting more wealth. I stress 'more' because I have yet to see a doctor that would not be considered rich. What has happened to the medical business? Where are the doctors who took interest in their work and patients? If people would start considering others more, instead of thinking only of how they can benefit, this world would be a much happier and peaceful place to live."

As physicians, however, we are loath to counter such charges because we may be accused of tooting our own horns. So when a non-physician, yet someone who understand how it really is, speaks up in our defense, we are truly grateful. Kaiser radiologist **Tom Brown's** son, Thomas Brown III, writes:

"In reference to criticism of doctors, I submit the following comments: My father is a practicing doctor in Honolulu. As I write this letter, he is working. Dinner was held until 7 o'clock this evening when he phoned to say he could not be home until 10. He has been gone since 7:30 this morning. This is not unusual. Ten-15 nights each month he is involved in staff, executive, medical board, nuclear medicine, etc., meetings, case discussions, report reviews, etc.

In the early years of my life, Dad was on 24-hour call seven days a week. During a ball game which we'd anticipate seeing together, he'd be called away on emergencies, leaving us to return alone. This was not a singular incident. In what other profession is one expected to perform so spontaneously when called upon? I feel he sacrificed much of his personal life for his profession.

Dad is 49 years old. He spent four years in college, three years in medical school, one year interning to qualify for general practice; then three additional years specializing. His salary started at $100; the family then consisted of three children, my mother, and a $125-a-month mortgage on the house. Because of the cost of professional training, he was unable to finish his medical studies until he was 35. This is almost half his life in formal schooling.

Dad still spends the majority of his unpaid time studying; this includes medical journals updating related fields of medicine. He does this voluntary studying in order to provide his patients with the most up to date and best medical treatment he can. I think this is more than enough to ask of the average man. I would like to know exactly who is being benefitted.

I am presently a student in the school of medicine. If letters to the editor criticizing doctors represent public opinion, I wonder whether it is worth the effort to become one in return for so little appreciation."

Doctors in Print

E. Gordon Dickie, "1976" (A dramatic novel exposing the real and unspeakable horrors that await mankind before his annihilation in the future—Ed Sherman.)

Robert G. Rigler and **Fred I. Gilbert,** "Screening of chest roentgenograms by a radiological assistant" Group Practice Vol 20 No 3 Mar '71 (A real life story of how an ordinary girl was trained to take and read Xrays.)

Kuakini Oncology Conference Dialogue

A 77-year-old woman was found at surgery to have carcinoma of her left breast and carcinoma of the head of the pancreas with metastasis. A choledochoduodenostomy was performed. Surgeon **Roy Tanoue:** "I need help." Internist **Quint Uy:** "How long was the interval

between the two Ca's?" Pathologist **Grant Stemmerman** who did the frozens: "About 30 minutes. This is a case of synchronous multicentric Ca's." Quint: "The treatment depends on the nutritional status. It is a question of how much drugs she can tolerate." Roy: "She is asymptomatic except for the jaundice." Stemmy: "I think we can forget the breast Ca." Quint: "I would try estrogen for the breast Ca and give her multiple drugs rather than a single drug for the pancreatic Ca." Surgeon **Glenn Kokame:** "We don't have any good drug for the pancreatic Ca. I would probably leave her alone if she is asymptomatic, but otherwise try multiple drugs." Internist **Tom Fujiwara:** "I'm surprised that no surgeon has suggested a Whipple, i.e. a simple mastectomy and a Whipple." Roy: "That entered my mind . . ." Stemmy: "I'm for a total pancreatectomy." Urologist **Masaru Koike:** "How long does it take to do a pancreatectomy?" Stemmy: "Shorter than a Whipple."

A 43-year-old woman was found to have adenocarcinoma of her breast with axillary node metastasis. Surgeon **Yutaka Yoshida:** "I don't think 5 FU is all that innocuous. You all think it is like giving water . . . I plan irradiation." Stemmy: "Since we've had such wretched results with 5 FU, we should try something else." Radiologist **Carl Boyer:** "Ansfield suggests Xray therapy with 5 FU. He gives radiotherapy for local recurrence." **Quint Uy:** "I would give 5 FU rather than do an oophorectomy." Moderator **Noboru Oishi** to radiologist **Ed Quinlan:** "Ed, would you use Xray therapy if a patient is started on chemotherapy?" Ed: "It doesn't make sense to give radiotherapy with chemotherapy." Stemmy: "Why not concurrent therapy?" Carl: "We tend to get emotional about this." Noboru: "My feeling is to give chemotherapy for 4 or 5 months, then interchange with Xray therapy."

Recollections of an Entertainment Chairman . . .

As we listened to this year's Kuakini Medical Staff party MC, **Henry Oyama,** bemoan the difficulties of organizing entertainment for the annual tea house stag event, we recalled our own experiences of a year ago when we had the same dubious honor. **Tom Fujiwara** and chief of staff, **Al Shimamura,** had been running this annual affair for over 15 years without fanfare and we quickly learned the intricacies of getting entertainers, volunteers, and yet staying within a tight budget. Unfortunately, we had the gall to suggest that we could dispense with the traditional strippers and keep the entertainment at a higher plane with Tripler troubadour **Maj Dierdorf** and master story teller-comedian-orthopod **John Smith.** We proudly mentioned this at an Executive Committee meeting three nights before the party, and instead of praise, we got an immediate adverse reaction . . . **Yutaka Yoshida** declared indignantly, "I ain't going to any party that doesn't have strippers." Even our pristine **Masaru Koike** demanded that we at least get topless waitresses . . . We were properly warned that one year we had community sing and everyone went home unhappy . . . How to arrange for topless waitresses or strippers with three days remaining? We asked Masaru to arrange for the topless waitresses he wanted so badly. He tried next day and failed. With two days remaining, we met **Phil Lee** who raved about a stag affair at **Allan Leong's.** We contacted Allan who informed us that **Bill Won** had arranged the entertainment. A hurried call to Bill and we obtained the name and phone number of a Mrs. K. . . . We called her and the following conversation ensued: "Mrs. K. . . ., we were referred to you by Dr. Won . . . We need some entertainers . . ." "What kind of entertainers?" "Well, we're hoping for topless waitresses or strippers . . ." "When do you need them?" "This coming Friday night." "Well, I can't get topless girls at such short notice, but I can get you belly dancers and strippers . . . The standard charge

continued page 348

LET US SHOW YOU HOW AN AVERAGE LAND INVESTOR ACTUALLY EARNED 66.35% NET RETURN IN ONLY 2 YEARS AT KONA HIGHLANDS

CALL 538-1106
And ask for Kona Highlands

PRIME LOCATION — only 7 miles from Kailua-Kona in the cool highlands, overlooking Keahole Jet Airport and Honokohau Marina.

FEE SIMPLE, PANORAMIC VIEW LOTS — sweeping, ocean view from the majority of gently sloping lots ranging in size from 8,389 to 13,705 sq. ft.

DE LUXE IMPROVEMENTS — include underground utilities, asphalt-paved, county-dedicated roads, modern street-lighting system — all developer-paid.

THERE IS NO MAGIC TO LAND INVESTMENT. IT'S SIMPLER THAN YOU THINK. LET US SHOW YOU HOW YOU TOO CAN REALIZE A GREATER RETURN FROM YOUR HARD-EARNED MONEY . . . AT KONA HIGHLANDS.



ACT NOW!

You owe it to yourself to inquire about this fabulous land investment opportunity. For complete information, simply mail back this reply slip . . . or call 538-1106.

I would like a free, full-color brochure, a subdivision map, and other information on KONA HIGHLANDS subdivision.

Name

Street

City State

Zip Telephone

Please mail to:
GREAT HAWAIIAN REALTY, INC.
547 Halekauwila Street
Honolulu, HI 96813 HMJ - 1

Hawaii Medical Ass'n *continued from 288*

ACTION:

It was voted to approve the Ilikai as the site of the 1972 Meeting if further studies into other facilities prove that the Ilikai Hotel offers "the best deal."

ELECTION OF OFFICERS OF THE COMMUNITY RESEARCH BUREAU

Dr. B. A. Richardson chaired this portion of the evening's session and reconvened the group to meet as the Community Research Bureau. Members of the Bureau are members of the HMA Council. Purpose of this meeting was to elect the four officers of the Bureau. Presently only three officers continue to qualify as Trustees. They are: Drs. Richardson, Chinn, and Tomita.

ACTION:

It was voted to have the following remain as officers: B. A. Richardson, President; Theodore T. Tomita, Vice President; and Herbert Y. H. Chinn, Treasurer.

ACTION:

It was voted to renominate and elect O. D. Pinkerton to the post as Secretary.

ACTION:

It was voted to charge the Board of Trustees with the duty of preparing a format whereby this corporation can become a fiscal agent if called upon to do so.

SPECIAL BUSINESS

New or Additional Space for HMA-HCMS Offices: Dr. Carl Lum addressed the Council with a progress report of the Site Committee's search for larger quarters to house the Bureau of Medical Economics with the combined HMA-HCMS staff. Dr. Lum elaborated on several proposals and courses of action that are under consideration. They are: (1) To stay on at Mabel Smyth Building since this still appears to be the best location, but to build an addition to the auditorium. Council approval was requested to ask Queen's Medical Center for a loan of $150,000 for construction of this addition. This will give an additional 3,000 square feet of space. (2) Move elsewhere—there is a location at Liliha Street which is under consideration. HMA is not obligated to remain in Mabel Smyth but is obliged through a clause in the contract which states that HMA must keep up the maintenance of the Bulding. If HMA moves to a different location and rents out the present space, it must be rented for approved medical or paramedical purposes. (3) Mr. Ossipoff, architect, recommends that a new two-story structure be built adjacent to the auditorium between the auditorium and the Hawaii Medical Library. However, in planning for the future, if HMA should require even more space within a few years, it is recommended that the addition to the auditorium be built first and then to construct the new two-story building.

ACTION:

Until additional information is available, the Council voted not to take action on any construction at this time.

UNFINISHED BUSINESS

School of Public Health Proposal: Dr. Lowrey reported on the feasibility study dealing with the health delivery system in Hawaii initiated by Dr. Edward O'Rourke of the School of Public Health. Dr. Lowrey sent an answer to Dr. O'Rourke outlining HMA's conditions of participation. The initial contract is to present data on the present situation in health care in various parts of Hawaii. If, on the basis of information gathered, the areas studied are interested in improving conditions in their areas, then they would apply for a grant. The areas under consideration are: (1) Molokai, (2) that part of Kauai which would be interested, and (3) Windward Oahu, between Waimanalo to Hauula, excluding Kaneohe. Dr. Lowrey will contact the Molokai doctors regarding their interest in this study. As for Kauai, Dr. Kim and Dr. Custer both thought their island would be agreeable to the study, but will report back after consultation with other physicians on the Island. There were no objections from the Council regarding the Windward study; however, there are certain problems still unresolved as to Oahu's participation. The Community Health Care Committee of the Honolulu County Society is recruiting physicians for the area under consideration.

Guidelines for a Professional Liability Insurance Committee: Guidelines prepared by the Ad Hoc Committee on Malpractice were presented for Council approval for a permanent Professional Liability Insurance Committee to deal with problems relating to professional liability insurance in Hawaii. The first function of the committee has to do with the availability of professional liability coverage for physicians. The second function is to judge medical liability. Appeals from the committee's actions may be made to the Adjudication Committee, then to the Council, and final appeal to the House of Delegates. The President is to appoint ten doctors to the committee for staggered two-year terms. Seven members are to be appointed from Honolulu County and one member each from the other counties.

ACTION:

It was voted to approve the guidelines for the Professional Liability Insurance Committee.

Opinion Survey: Murray Klutch, Director, Division of Socio-Economics and Research, California Medical Association, was asked to do the analysis of the Opinion Survey prepared recently by the Public Relations Committee. In his answer, Mr. Klutch asked for more information such as "what kinds of correlations did HMA have in mind for the analysis?" He indicated that the analysis will cost a considerable sum of money if it is to be correlated in any meaningful form. It was decided to contact a statistician knowledgeable in this area for an opinion whether it is worthwhile to have this survey analyzed at all, or to advise HMA as to what can be done with it.

NEW BUSINESS

Workmen's Compensation: The Honolulu Neurological Society, together with the Hawaii Association of Medical Clinics, is prepared to present a writ of mandamus to Robert Hasegawa, State Director of Labor, requesting that the updated medical fee schedule be published. Mr. Hasegawa had said that the schedule would be ready by Christmas of 1970. It was pointed out that the schedule is in the Governor's Office but, to date, it has not been released. Dr. Nicholson and Dr. Poulson urged HMA to join the other two organizations in their effort toward resolution of this long-standing, unresolved problem. An unofficial poll taken of the HMA Workmen's Compensation Committee by Dr. Nicholson indicated members supporting the writ of mandamus. The Council was reminded that this action is not a suit; it is asking a public official to show just cause why he does not produce a document which should have been produced long ago. It is the recommendation of Mr. V. Thomas Rice, HMA's legal counsel, that HMA approach the Governor's office in an effort to get some

continued page 346

For those times
when you
need a hand.



When you need a financial helping hand, turn to one of the 12 Central Pacific Bank offices located throughout the state. For an individual, a family, a business, no problem is too large . . . or too small.

cpb
Central Pacific Bank
"The Bank that
helps you get
things done"

Member Federal Deposit Insurance Corporation

action with a time limit, and if there is still no action, then indicate the HMA will be forced to proceed with the other organizations.

ACTION:

It was moved and seconded "that the Governor's Office be approached to get Mr. Hasegawa to produce the new fee schedule as he promised and if nothing is produced within two weeks, then HMA will join the other groups in the writ of mandamus." Motion carried. Dr. Tomita and Dr. Goto will represent HMA in approaching the Governor.

Election of Members to the Finance Committee:

ACTION:

It was voted to approve the slate of nominees for the Finance Committee as presented by the President. They are: Thomas P. Frissell, Chairman; M. J. Aveeilla, Robert Chung, William W. L. Dang, H. William Goebert, Jr., Kiyoshi Inouye, and Theodore T. Tomita. (Treasurers of county societies are automatically members of the Finance Committee. They are: Robert Berry, Kauai; William F. Moore, Oahu; Allan S. Takase, Hawaii, and John N. Withers, Maui.)

Election of Members to the Bureau of Research and Planning:

ACTION:

It was voted to approve Dr. J. I. Reppun as chairman of the Bureau of Research and Planning Committee and all other members as nominated by the President. They are as follows: Samuel P. Allison, Elisabeth Anderson, Douglas Bell, II, Richard K. Blaisdell, Claude Caver, Cesar B. deJesus, Lawrence H. Gordon, Masato Hasegawa, George Henry, Robert L. Kistner, Namiko Kominami, Wallace Loui, Wilbur Lummis, Richard Maniya, James L. Mertz, Robert Peyton, Theodore T. Tomita, Casper F. Rea (Kauai), J. Mark B. Sowers (Maui), and R. P. Wipperman (Hawaii).

The Hawaii Medical Care Review Organization: Mr. Jon Won briefed the Council on developments to date relative to the grant application to HEW, National Center for Health Services Research and Development, for funds to establish an Experimental Medical Care Review Organization in Hawaii. The objectives of the proposal are: (1) To provide consultation and technical staff assistance for continuous hospital-based medical care review, (2) To develop the procedural and technical methodology for effective review of the quality of ambulatory care in a variety of settings, and (3) To provide a continuing system of interval feedback on quality of ambulatory and hospital-based patient care.

Applicant organizations are the Hawaii Medical Association and the Research Corporation of the University of Hawaii. The Regional Medical Program of Hawaii agreed to supply the staff and performance site. Dr. Alexander Anderson, Consultant in Continuing Medical Education, RMP, will be the Principal Investigator. Due to the time limit for submittal of the proposal, the applicant organizations were pressed for time; however, with Dr. Anderson writing up the project, the grant request was submitted on time. HMA has been advised that the proposal has received preliminary acceptance and that a conference is scheduled on June 8, 1971, in San Francisco at which time it is requested that the HMA President and a representative from HCMS be present.

ACTION:

It was voted to send two representatives from the State to be selected by the HMA President to the conference on the Hawaii Medical Care Review Organization grant request. If the grant is approved, the cost of the trip to be reimbursed from the grant. It was recommended that a letter of thanks and commendation be sent to Dr. Anderson for his invaluable assistance in preparing the grant.

Position of Assistant to the President: The House of Delegates adopted Resolution No. 6 relating to the establishment, if feasible, of a position on the staff at the professional level to act as an assistant to the president and officers to expedite and correlate the functions of the Association. His salary will be taken from funds allocated for the public relations counsel. A job description and table of organization for the new position were presented for Council approval. The Assistant to the President will be directly responsible to the President of HMA to (1) represent the President in matters requiring professional activity when directed to do so by the President, (2) reflect the policies of the Association as directed by the President, and (3) assume such other duties as may be assigned by the President. The choice of the applicant is to be the prerogative of the President.

ACTION:

It was voted to approve the job description with the table of organization for the Assistant to the President.

ACTION:

It was voted to authorize the President to spend up to $500.00 a month for the position of Assistant to the President for the fiscal year, subject to review by Council at end of fiscal year.

continued page 361

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.



ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Honolulu Orthopedic Supply...

a new name in town where you don't have to give an arm and a leg for better service.

Our complete facilities provide the best in artificial limbs, braces, supports, splints and other orthopedic appliances.

But it doesn't stop here. Our primary concern is people, whether physician or patient, and that means service!

We also carry a complete line of ambulatory aids for rent or sale, featuring Everest & Jennings products. We're here to help, so call us, anytime!

1365 Nuuanu Avenue • Phone 536-6077 • Rodney M. K. Pang, Certified Prosthetist

OXYGEN AIR-CONDITIONED

24-HOUR SERVICE

Physician's



531-0477

AMBULANCE SERVICE, INC.

Hawaii's Finest

Dial
537-5353
for
the finest printing service
in the state

star-bulletin printing company
420 WARD AVENUE HONOLULU, HAWAII 96814

it's
the real
thing

Enjoy
Coca-Cola
Trade-mark ®

COCA–COLA BOTTLING COMPANY
OF HONOLULU, INC.

is $100.00 for their routine . . . We have a girl that does both belly dancing and exotic dancing . . . for almost an hour . . . Her name is Tanya" . . . (We were elated; having seen all the nude profiles of the girl on the Tanya Suntan lotion ads, we just knew she was our girl.) "Let me call you right back after I contact her." So she hung up and we waited and fidgeted . . . Five hours later and no return call . . . We phoned Mrs. K. . . . again: "Yes, Tanya is available . . . but there will have to be a contract and there are certain conditions . . . Tanya doesn't like mats in teahouses because she nearly flipped over once . . . You must get rid of mats . . . Also she needs a mike and amplifier . . ." (We agreed to the terms.) "Can you find someone in the audience to play with her?" (We promptly thought of **Paul Gebauer,** but as it turned out, **Carl Mason** did the honors and he stole the show from Tanya.) "Our girls are union members and carry insurances which you pay . . ." "How much?" we inquired timidly. "One dollar and 50 cents." (We sighed in relief.) "Who can I contact to verify that there will be a party?" (She explained that she had once sent entertainers over to an address given and it turned out to be an empty church . . . So she had to make sure that the same thing did not happen.) We asked her to call the top man, the hospital administrator, **Masa Tasaka** . . . Poor Masa, he is probably still wondering who steered a Mrs. K. . . . to him. "Do you want pasties or spangles?" (What an odd choice, we thought . . . but pasties sounded tastier and so we chose pasties . . . but then we had the temerity to ask what they were . . . There was a quiet chuckle.) "Tanya prefers to leave her G strings on." (And we concurred.) After further discussion of similar delicate details, we agreed to sign the contract at Natsunoya on the night of the entertainment, that Tanya will be paid the stipulated sum and that . . . all the intricate conditions would be met . . .

Cause for Alarm!

We as physicians are supposedly inured to the concept of death. Yet, when we review the physician obituaries for the past year, we note with alarm that of the 10 physicians who died, at least nine died prematurely, assuming, of course, that the average life span of the American male to be in the neighborhood of 70. Listed in chronological order, in May last year, **Lester Kashiwa** died at age 52; in July, **Phil Chu** also died at 52; in November, **John Stephenson** died at 43; and in December, **Zenko Matayoshi,** the only exception, died at the ripe old age of 78. In January this year, **Wilfred Kurashige** died at age 58 and **Ed Cushnie** at 66; in February, **Albert Okumura** died at age 66; in March, **Lloyd Guthrie** died at 34; in April, **Keith Kuhlman** died at 47; and in June, **Edmund Lee** died at age 63. Whether death was by disease, accident, or otherwise, we know our profession to be the primary cause, either direct or indirect. It behooves us to reflect seriously upon our own physical and mental healths and take the necessary preventive measures either individually or collectively . . . Who was it that said, "Physician, heal thyself"

Announcements

CALL FOR ABSTRACTS

The Regional Meeting of the American College of Physicians will hold its annual meeting February 22-23, 1972, in Honolulu.

Contributions to the Scientific Program are solicited. Special consideration will be given to papers from students in the field of health sciences, house officers, and Members of the College.

Abstracts (250 words or less) should be submitted by **NOVEMBER 1, 1971** to: K. D. Gardner, Jr., M.D., F.A.C.P., Chairman, Scientific Program Committee, Hawaii Region, American College of Physicians, 3675 Kilauea Avenue, Honolulu, HI 96816.

DEMOGRAPHIC CANCER RESEARCH AND TRAINING IN HAWAII

A planning and development grant has been awarded to the University of Hawaii, Dr. Richard K. C. Lee, Principal Investigator. A proposal is being developed in conjunction with the University Cancer Research Center which has been organized to include a broad representation from involved individuals of the lay, medical and University communities.

The Program Committee invites applications from individuals with interest in demographic aspects of cancer research to write short proposals for consideration and possible inclusion in the final overall proposal. Research is to be focused on demography and epidemiology and can include experimental and laboratory studies where relevant. Animal models to test hypotheses already generated by epidemiologic and demographic studies can be proposed. Applications should consist only of the following: page 1—Title, Principal Investigator, and Specific Aims; page 2—Methods of Procedure; page 3—Facilities and Budget. The budget should be realistic, and personnel undergoing training should be so designated. Applications, one copy, should reach the Chairman of the Program Committee (Field and Laboratory) (Telephone 944-8838), Dr. F. C. Greenwood, University of Hawaii, Department of Biochemistry and Biophysics, Biomedical Sciences Building, 1960 East West Road, Honolulu, Hawaii 96822 on or before Wednesday, September 1, 1971.

CONFERENCE: NATIONAL HEALTH INSURANCE —IMPLICATION FOR HEALTH CARE DELIVERY SYSTEM

Sponsored by the Western Region Assembly of Constituent Leagues for Nursing, this multi-disciplinary conference will be held at the Sheraton Inn Airport, San Diego, Cal., September 27-29, 1971. Further information and application may be obtained from: Western Office, National League for Nursing, 760 Market St., San Francisco, Cal. 94102. Registration deadline: September 17.

POSTGRADUATE COURSE: OTOLARYNGOLOGY FOR THE FAMILY PHYSICIAN

Presented by the Department of Otolaryngology, University of Miami School of Medicine at the Sheraton Four Ambassadors Hotel, October 8-9, 1971. AAFP credit: 9 hours. Course Director: F. W. Pullen, II, M.D., Neuro-Otologic Laboratory, School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

POSTGRADUATE COURSE: ENDOCRINOLOGY AND METABOLISM

Presented by the American College of Physicians September 20-24, 1971, Duke University Medical Center, Durham, N.C. For information and application write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

POSTGRADUATE COURSE: RHEUMATIC DISEASES: PATHOLOGY, IMMUNOLOGY, DIAGNOSIS AND TREATMENT

Presented by the American College of Physicians October 18-22, 1971, Francis A. Countway Library Auditorium, Boston, Mass. For information and application write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

continued page 352

MEDICAL PLACEMENT BUREAU
and
NURSES' REGISTRY

24 HOUR SERVICE

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

1415 Kalakaua Avenue **Suite 210**
Phone 949-1237

VB

NATIONAL ASSOCIATION OF REAL ESTATE BOARDS REALTORS

–ALOHA!–

The personalized service offered by our experienced staff can make house-hunting in Hawaii easy and pleasant. Inquiries welcomed!

VB

VELVA BERGEVIN, LTD.
Realtors

2222 Kalakaua Ave., Suite 1215
Honolulu, Hawaii 96815

PHONE 923-1888

Cable Address: VBLTD

MEMBERS MULTIPLE LISTING SERVICE

MATLES ROTO-SLEEPER (SABEL)

A new straight last and outflare shoe attached to an extended plate with the angles of a tetragon. Applicable to mild problems requiring external or internal rotation. Action can be taken now instead of delaying therapy.



NEW SABEL NIGHT SPLINT PROGRAM

Splints of new, light weight extra strong metals can be returned for credit, saving patient money. Sabel's new heel for pre-walker surgical and pre-walker club is an elasticized, water repellent insert that guarantees maximum comfort.



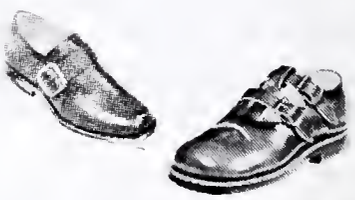
NEW FLEX - O - SPLINT (TARSO)

For internal tibial torsion and related problems of feet and legs.



BASIC STRAIGHT LAST SHOES (SABEL)

Thomas heels (no wedges), long medial counters, steel shanks. Good selection in colors, and styles. A good basic shoe to receive the doctor's prescription.

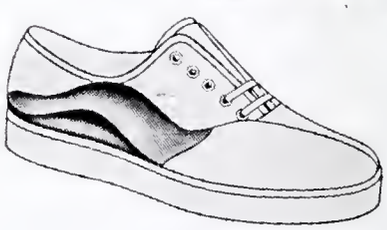


FLEXIES — REGULAR STRAIGHT LAST SHOES (SABEL)

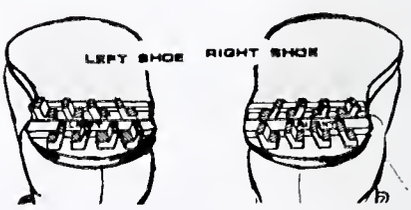
Feature a free shape, giving maximum freedom to the forepart of the foot—offers least possible restriction for the natural growth of the tiny feet.



SNEAKER MOLDS (SABEL). Added support for the little one's "tennies"—light weight and perspiration resistant.



TORQ HEELS (SABEL). "A step in the right direction." A carefully engineered simple orthopaedic heel creating torque or rotation at heel strike, providing therapy to correct toe in and toe out condition.



Teeny Tots' Footwear

PHONE 538-6163 1111 BISHOP ST.

Carnation
EVAPORATED MILK

HAWAII'S HEALTHY BABY MILK...



1970
Carnation Healthy Baby Contest
$1,000 1st prize winner,
David Culver Holbrook
of Honolulu, Hawaii



1st CHOICE FOR INFANT FEEDING...
No. 1 in the Islands for generations,
...available everywhere in Hawaii

"from Contented Cows"

Notes and News *continued from 349*

AMERICAN ACADEMY OF CLINICAL TOXICOLOGY FOURTH ANNUAL MEETING

October 21-23, 1971, Marriott City-Line Motel, Philadelphia, Pa. The meeting is open to all who are interested in problems of prevention, diagnosis, and treatment of diseases caused by toxic substances. Pre-registration is encouraged. Training programs: Identification of Drugs and Toxic Substances in the Emergency Room, October 20; Principles and Practice of Clinical Toxicology, October 19 and 20. Further information and registration forms are available from the American Academy of Clinical Toxicology, P.O. Box 2565, Houston, Tex. 77001. Exec. Dir., Eric G. Comstock, M.D.

POSTGRADUATE COURSE: RECENT PROGRESS IN CLINICAL CANCER

Presented by the American College of Physicians October 25-29, 1971, Memorial Sloan-Kettering Cancer Center, E. 68th St., New York, N.Y. For information and application: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

FIFTH ANNUAL CONFERENCE—TODAY'S HOSPITAL PROBLEMS: AN INTERDISCIPLINARY APPROACH

November 10-13, 1971, Tides Hotel and Bath Club, Redington Beach, Fla. This postgraduate conference is specifically designed for Chiefs of Staff, Hospital Administrators and Governing Personnel (or Trustees). Information and application: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

SYMPOSIUM ON PEDIATRIC NEUROLOGY

Presented by UCLA Extension's Continuing Education in Health Sciences and the UCLA School of Medicine, October 16-17, 1971, in the auditorium of the Neuropsychiatric Institute at UCLA. For further information write: Donald Brayton, M.D., Director, Dept. of Continuing Education in Health Sciences, Rm. 15-39, Rehabilitation Center, University Extension, UCLA, Los Angeles, Cal. 90024.

AMERICAN ACADEMY OF DERMATOLOGY 30TH ANNUAL MEETING

The Academy plans two days of postgraduate courses followed by scientific sessions December 4-9, 1971, at the Palmer House, Chicago, Ill. Information: Frederick F. J. Kingery, M.D., Secretary-Treasurer, 2250 N.W. Flanders St., Portland, Ore. 97210.

CONTINUING MEDICAL EDUCATION PROGRAM

The program entitled "Coronary Artery Disease and Cardiac Arrhythmias" will be held on November 19, 20 and 21, 1971 at the Surfrider Hotel, Honolulu. Co-sponsors: The American College of Cardiology in cooperation with the University of Hawaii School of Medicine. For further information, write: Miss Mary Anne McInerny, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

For WHO HAVE BEEN EVERYWHERE World Travelers



HAWAII CONDOMINIUM RENTALS: Enjoy a quiet week or month of just plain beauty, swimming and hiking in tropical Hawaii. Just 7 miles beyond the Princeville Golf Course (less than that for deep sea fishing!). HANALEI COLONY RESORT on the North Shore of Kauai, Hawaii's Garden Island. Nestled in giant Australian pines, right on the pounding surf of the Pacific. No night life; just the tropical moon. Two large bedrooms accommodate 4. Complete kitchen with refrigerator, washer/dryer. Daily rates for 2 from $26. Weekly and monthly rates also are available.

For a week or month of beautiful quiet, tropical living, write:

Hanalei Colony Resort

For reservations call collect Kauai 826-6235

AMERICAN BOARD OF FAMILY PRACTICE EXAMINATION FOR CERTIFICATION

The examination will be held in various centers throughout the United States, April 29-30, 1972. Information can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Rm. 229, Lexington, Ky. 40506. Application deadline: February 1, 1972.

THE TWELFTH CONGRESS OF THE PAN-PACIFIC SURGICAL ASSOCIATION

Concurrent meetings will be held in: Anesthesiology, Colon & Anorectal Surgery, General surgery, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-cardiovascular, and Urology. Date: February 26 to March 4, 1972.* Place: Hilton Hawaiian Village Hotel, Honolulu, Hawaii. For details, write: Cesar B. DeJesus, M.D., Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

* Please note change in date from March 3 to March 4, 1972.

County Society News *continued from 334*

members." Second correction: . . . "*federal government is* interested in establishing prepaid capitation plans" . . . and deletion of "and he was elected" so as to read "Dr. Uehara was nominated unanimously," and changing of ODs to read DOs. The minutes were approved as corrected.

Dr. McCollum reported that a malpractice case is pending on Molokai; the Adjudication Committee has forwarded information, if the assistance is requested.

Dr. Sowers stated that at the HMA House of Delegates meeting, the Maui County resolution for investigating acceptance of DO's into the State and County Medical Societies had been passed after several deletions.

Dr. Alexander Peat's application for membership was approved.

A letter was read from the Maui County Committee on Aging stating that elderly people were available for household jobs.

Dr. Sowers read a letter from Dr. Chinn regarding funds from HEW for continued review of medical care. A letter has been sent in response to Dr. Chinn.

* * *

The June 15 meeting was attended by 19 members.

Guest speaker, Dr. George W. Starbuck, Medical Director of the Children's Protective Services Center in Honolulu, spoke on the "Recent Advances in the Diagnosis and Treatment of the Abused Child."

Dr. Starbuck introduced the background data of the abused child and presented the data collected since the inception of the agency from mid-1969 until the present. Over 700 suspected cases were reported with 384 cases confirmed during this period.

He emphasized that 5% of the children had parent(s) with psychotic behavior and stressed that future abuse can be expected in almost all cases. His agency has worked with the DSS and emphasized a team approach to the care of each of the cases.

Dr. Sowers announced that Don Harper Mills, M.D., J.D., has offered to speak to the Staff on August 12 or 13, 1971 on the current medical-legal aspects of medicine. A definite schedule will be announced later.

The sculptured beauty of Buick

Any one of Buick's set of values for 1971 offers a unique experience in unmatched comfort and styling. Experience new dimensions in driving pleasure; test drive the 1971 Buick . . . something to believe in.

SCHUMAN CARRIAGE CO.

1234 So. Beretania St. • Honolulu • Telephone 533-6211

Honolulu's Authorized Buick and Cadillac dealer



INSURANCE EXCLUSIVELY

Brainard & Black, Ltd.

1712 S. King Street, Honolulu 96814

Telephone: 949-0031

"Small enough to know you, Large enough to serve you"

Hawaii Pharmacists' Bull. *continued from 338*

to be allotted the Legislative Committee. R. Yoshino suggested that before allocating moneys the committee should first: (1) Outline a projection of what the committee will do before the legislative session convenes. (2) Decide whether an attorney would be hired. (3) Work constructively with as many knowledgeable people as possible. (4) Arrive at a figure cost of such a program.

B. Bell suggested that the need for inspectors to protect pharmacy and implement the need of the Board of Pharmacy be promoted. A motion was made and passed that G. Pang contact various attorneys in the medical field and come up with a definite plan before any money be allocated.

R. Yoshino invited the board members to all Pharmacy Board meetings; the next scheduled one is September 23, 1971, Board Room, Department of Regulatory Agencies, 1010 Richards Street, Honolulu. Noel Evans invited the Board of Pharmacy members to all the HPHA Board Meetings. N. Chang suggested that R. Yoshino convey the wish to work in conjunction with the Board of Pharmacy.

Board Meetings will be changed to the 2nd Thursday of each month at 7:30 P.M., Kuakini Hospital, Makai Board Room.

A motion was passed to pay A. Meyers $3,000.00 for the collection donated by the Hawaii Pharmaceutical Association to the Bishop Museum.

The Pharmacy Directory is being printed and will be distributed soon.

The Fall Seminar will be held September 14-16, 1971. A motion was carried to allot a minimum of $1,000.00 for seminars. L. Wong reported that the seminar will be a review of subjects on the Pharmacology of Pain. Professors from the University of the Pacific will participate.

Membership was discussed and James McElhaney suggested a plan of action for the HPHA on Drug abuse.

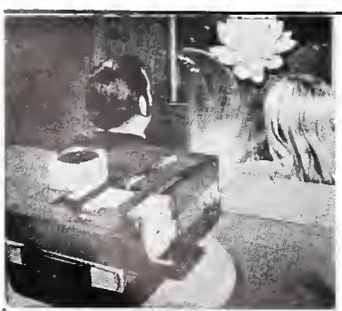
Book Reviews *continued from 285*

Symposium on Hemopoietic Cellular Proliferation

Edited by Frederick Stohlman, Jr., M.D., 333 pp., illus., $19.75, Grune & Stratton, 1970.

A SYMPOSIUM on hemopoietic cellular proliferation was held at the St. Elizabeth's Hospital in Boston, Mass. November 5-6, 1969. The proceedings of this meeting have now been published in this compact book. The papers have been incorporated into five sections, i.e., general considerations of hemopoiesis and the pluripotential stem, the relationship of bone marrow structure to hemopoiesis and myeloproliferative syndromes, the control of red cell production, granulopoiesis and leukemia, and the control of platelet production. Some very basic studies are presented and much new information continues to be accumulated at a very rapid rate, giving us a better understanding into hemopoiesis.

ROBERT T. S. JIM, M.D.



Only $269.50 w/20mm f1.3 lens.

HAWAII CAMERA CO LTD



For those special close-up shots from 1" to infinity or for general Super 8 movie making from 8 to 1 Zoom range select the all new BOLEX 280 Macrozoom camera today! **Only $319.50**

Bolex has perfected the world's only Super 8 projector with a built in automatic cartridge changer. The Bolex Multimatic Super 8 projector holds up to six cartridges.

You are invited to come in for free demonstration.

Hawaii's Most Complete BOLEX Headquarters

HAWAII CAMERA CO. • 1415 KAPIOLANI BLVD., HONOLULU, HAWAII 96814 • PHONE 949-5321

WONDA-CHAIR
NO FINER BABY SAFETY EQUIPMENT IN THE WORLD
PROVIDING— • ABSOLUTE SAFETY • QUALITY • CONVENIENCE • ECONOMY
Since being introduced WONDA-CHAIR *has been awarded*
A. PARENTS MAGAZINE COMMENDATION — B. GOOD HOUSEKEEPING SEAL
C. AMERICAN MEDICAL ASSOCIATION AUTHORIZATION
Franchised Hawaiian Dealer is
M & S DISTRIBUTORS
1614 KALAKAUA AVE. — PHONE 949-0908
NOT SOLD IN STORES

Recent Advances in Researches on Filariasis and Schistosomiasis in Japan

Edited by Manabu Sasa, $21.00, University of Tokyo Press, 1970.

THIS IS A multi-authored collection of papers presented at a symposium on filariasis and schistosomiasis, sponsored by the Japan-U.S. Cooperative Medical Science Program. It is fairly well written except for the introductory portions of each section where some of the sentences are in an unusual style that is sometimes difficult to decipher. As with most texts of this type, there are frequent repetitions by different authors. There are many references to the various prefectures of Japan and a labelled map would be most helpful to those of us unfamiliar with them.

This volume should be a good reference for those interested in filariasis and schistosomiasis but will probably not be added to many physicians' personal bookshelves. The technics used in the epidemiologic studies and control of these two diseases may be of interest to those in public health. Skin testing was a more sensitive tool than stool examination in schistosomiasis and blood smear examination for microfilaria, but could not distinguish active from inactive disease. The mosquito control in filariasis and snail population control in schistosomiasis were important factors in decreasing the incidence of these diseases in Japan. Their incidence increased during and immediately after World War II because of the difficulty in implementing control measures.

Many feel that golfing promotes good health—at least this is what our wives are told. One of the papers in this symposium provides further evidence of golf's benefits. A golf course was built in an endemic area of schistosomiasis in the Chikugo riverbed located in the Saga prefecture of Kyushu. This altered the usual vegetative ecology and led to the extinction of the intermediate host snail population with a resultant decrease of the disease.

F. H. FUKUNAGA, M.D.

★Current Status of Drugs in Cardiovascular Disease

Edited by Charles K. Friedberg, M.D., 262 pp., $9.75, Grune & Stratton, 1970.

EACH OF THE 14 chapters in this slim volume has appeared as an individual article in the recently published "Progress in Cardiovascular Diseases."

The first chapter, by Marianne J. Legato, describes the ultrastructure of the mammalian heart cell and relates this to its function. The remarkable electron micrographs and the schematic line drawings with the beautifully written text clearly depict the complex relations in the functioning heart.

The remainder of the book describes the basic pharmacology of such drugs as digitalis, beta-adrenergic blocking agents, anti-arrhythmic drugs and diuretics. These discussions are, however, in depth and the full ranges of pharmacologic effects are described.

This text should be read by everyone but I suspect that its major appeal will be to cardiologists.

BERNARD W. D. FONG, M.D.

continued page 356

FREE DELIVERY
349 YOUNG BLDG.
537-6378
SUMMERS
PRESCRIPTION
SHOPS
Professional Courtesies
CHARGE PRIVILEGES
416 ALA MOANA BLDG.
941-9027

ISLAND NURSING HOME
MEDICARE CONVALESCENT HOSPITAL
CERTIFIED AS A PARTICIPATING EXTENDED CARE FACILITY FOR HEALTH INSURANCE UNDER SOCIAL SECURITY
24-HOUR NURSING CARE
(REGISTERED NURSES)
Closed Circuit TV Supervisions • Provides Instantaneous Attention
ALL ROOMS — LIGHT — CLEAN — AIRY
Sun-Warmed Lanais and Roof Garden Patios • Reasonable Rates • Convenient Visiting Hours
MR. WILBERT Y. YAGI, *Administrator*
DIAL 946-5027
1205 ALEXANDER ST., CORNER OF BERETANIA
NEAR CENTRAL UNION CHURCH

Book Reviews *continued from 355*

★Progress in Gastroenterology, Vol. 2

Edited by George B. Jerry Glass, M.D., 543 pp., $29.50, Grune & Stratton, 1970.

THIS VOLUME WILL be of interest to surgeons, internists, clinical pathologists, and radiologists. The chapter on gastric secretory function will be of practical usefulness to clinics and hospitals interested in instituting tests of gastric secretory physiology. An outstanding summary of manometry and related techniques in hiatal hernia, gastroesophageal reflux, esophagitis, and esophageal motor disorders is presented by Dr. Bernard Cohen. This chapter discusses the usefulness of manometric techniques in the diagnosis of lower esophageal sphincter incompetence, diffuse spasm of the esophagus, and hypertensive esophageal sphincter. The value of intraluminal pH recording in detecting gastroesophageal reflux is emphasized. The chapter should be of interest to all those dealing with gastroesophageal disorders.

Excellent summaries of the Zollinger-Ellison syndrome and multiple endocrine adenomas, carcinoma of the body and tail of the pancreas, malignant lymphoma of the gastrointestinal tract, disaccharidase deficiencies, celiac disease, gluten enteropathies, toxic dilatation of the colon, and recent advances in pediatric gastroenterology are presented.

This is a highly recommended volume for those interested in the above topics.

DAWSON DURDEN, M.D.

Surgery and Biology of Wound Repair

By Erle E. Peacock, Jr., M.D., and Walton Van Winkle, Jr., M.D., 630 pp., $21.50, Saunders, 1970.

THIS BOOK IS PRIMARILY a reference work and its chief interest would be to plastic surgeons, orthopedic surgeons, and to a lesser extent, general surgeons.

The first six chapters are rather tedious reading but are full of the type of detailed surgical research alluded to in the title. The chapters on burns and tendon repair are particularly well done.

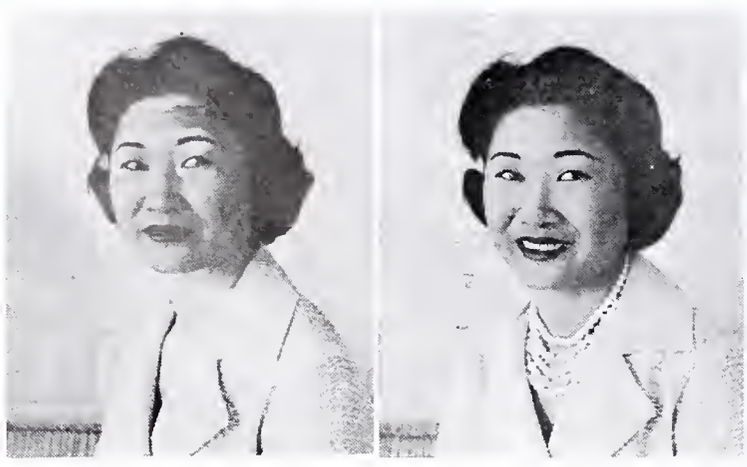
F. WARSHAUER, M.D.

Theory and Problems of Child Development

David P. Ausubel, Ph.D., and Edmund V. Sullivan, Ph.D., 2nd ed., 650 pp., $13.75, Grune and Stratton, 1970.

THE MAJOR ASSETS of this updated revision include the following: (1) academic completeness and thoroughness; (2) presentation of vast quantities of data within a logical frame of reference; (3) applicability of child developmental data especially to the realm of education (the field of interest of the authors).

Among liabilities I should mention: (1) the dry quality of literary style seemingly almost inherent in textbooks of this size; (2) a clinician will be a bit offended by the weighting of the references, e.g. only three references to Lois Murphy and two references to rather early Erik Erikson (one wonders if the updating was complete or only in selected areas); (3) overall, the non-


BLEMISHES?
COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.
Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 949-3288

ZIMMER
MEDICAL INDUSTRIES, LTD.
MILTEX

ORTHOPEDIC EQUIPMENT & SURGICAL INSTRUMENT SPECIALISTS

Don Bloedon
John McCready

Phone 949-0396
949 McCully Street, Room 11
Honolulu, HI 96814

clinical orientation of the material. In all fairness to the authors, however, it must be mentioned that the work is explicitly intended as an advanced textbook for graduate students in psychology and education, and only as a reference source for pediatricians, child psychiatrists, nurses, etc. Perhaps for this very reason it should be included on the shelves of a good medical library.

GEORGE C. BOLIAN, M.D.

Frozen Blood: A Review of the Literature, 1949-1968

By Arthur R. Turner, M.D., 206 pp., $19.50, Gordon and Breach, 1970.

THIS SLIM VOLUME is a narrative compendium of articles pertaining to the freezing and storage of blood. The first chapter is historical and includes references prior to 1949. The final chapter concerns reports of clinical experience with frozen blood. The eight chapters between deal with various aspects of the theory, technique, and experimental development of cryopreservation of blood. Erythrocyte survival receives much attention, but there is one chapter devoted to the ability of non-erythrocyte constituents to survive freezing and thawing The final fifty pages of the book are bibliography.

The scope of this book is extremely narrow; except for the chapter on clinical experience it would appear to be of limited value to the clinician. However, it is an excellent reference source for the subject and would be a logical addition to any blood bank library.

ANN B. CATTS, M.D.

The Primary Visual Motor Test; with Test Manual and Scoring Instructions

Mary R. Haworth, Ph.D., 174 pp., $10.75, Grune & Stratton, 1970.

THE PRIMARY VISUAL MOTOR TEST is a well designed objective measure of the ability to draw or copy from a model, for children between the ages of 4 and 8. Dr. Mary R. Haworth has obtained considerable data and experience over ten years of work with this instrument. The size of the normative group is impressive, with 100 subjects at each of the five age levels. The norms suffer somewhat with the limitation to the white population of a midwest community (Lincoln, Nebraska).

The uniqueness of this test instrument is questionable. Koppitz' earlier work with the Bender-Gestalt reproductions of children between 5 and 11 years of age filled a major gap for psychologists familiar with the Bender of adult subjects. The PVMT has data on 4-year-olds, but the relevance of assessing the copying ability of preschoolers is still debatable.

The potential utility of the PVMT is enormous; however, this manual leaves the clinician with much to be desired with its paucity of validation data. The book has subtitles under "Clinical Studies," such as "Traumatic Head Injuries," "Learning Disabilities," and "Childhood Psychosis," but the samples studies are much too small to rely upon for diagnostic assessments. A test like the PVMT would appear to be most useful with children

continued page 358

WILLIAMS MORTUARY
"CHAPEL OF THE CHIMES"
1076 S. Beretania St., Phone 537-2587
Ample Parking Adjoining Mortuary
OVER A CENTURY OF SERVICE
"Service measured not by gold but by the Golden Rule"
MEMBER
National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

having academic difficulties, yet only eight boys with learning disability are subjected to the PVMT evaluation.

Psychologists and educators may find the PVMT a most useful test instrument in the future. Much more research with varied clinical populations is needed before its full value can be realized.

WILLIAM T. TSUSHIMA, Ph.D.

Ophthalmic Plastic Surgery, 4th Ed.

By Sydney A. Fox, M.S. (OPHTH.), M.D., F.A.C.S., 590 pp., $29.75, Grune & Stratton, 1970.

I HAVE WATCHED Sidney A. Fox's *Ophthalmic Plastic Surgery* improve with each edition to provide a much needed text in this area. The first four chapters consist of general surgical principles, included for completeness. The remaining chapters are more specifically useful when one has a particular plastic surgical lesion to consider. These are classified as to type: ciliary margin lesions, medial canthal lesions, conjunctival repair, ptosis, etc. Each such chapter is very well illustrated either with drawings or photographs of the particular condition to be corrected, with clearly drawn diagrams of the methods used for this correction. The author's comments of his technique or possible causes for failure of a particular technique add much value to the book. This text should be used as a ready reference for a quick review when anyone is considering an ophthalmic plastic surgical problem. For those interested in further information, the bibliography is very complete.

WAYNE W. WONG, M.D.

Hernia Repair Without Disability; A Surgical Atlas Illustrating the Anatomy, Technique, and Physiologic Rationale of the "One Day" Hernia

By Irving L. Lichtenstein, M.D., 210 pp., $26.50, Mosby, 1970.

THIS IS A very attractively bound atlas containing many detailed drawings of the anatomy and the step by step details of the various types of herniorrhaphy. Included is a resumé of the history of the economic significance of this condition. There is also a chapter on anesthesia for herniorrhaphy.

This atlas will be especially useful to the medical student, intern, and resident learning the various techniques for repairing hernias. The practicing surgeon may also find it useful in reviewing and perhaps re-evaluating his approach to the repair of the various types of hernia as encountered in his practice.

ROY I. IRITANI, M.D.

Also Received

Progesterone: Its Regulatory Effect on the Myometrium, Ciba Foundation Study Group No. 34

Edited by G. E. W. Wolstenholme and Julie Knight, 193 pp., $3.60, J. & A. Churchill, 1969.

ANOTHER EXCELLENT SYMPOSIUM which should be of great interest to gynecologists and endocrinologists.

BESS
OFFICE PRODUCTS CENTER

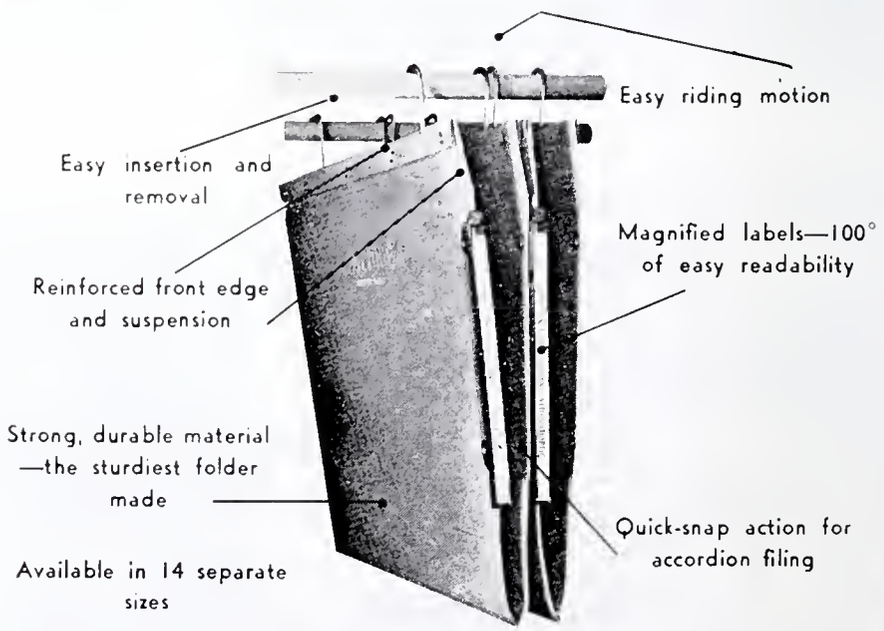


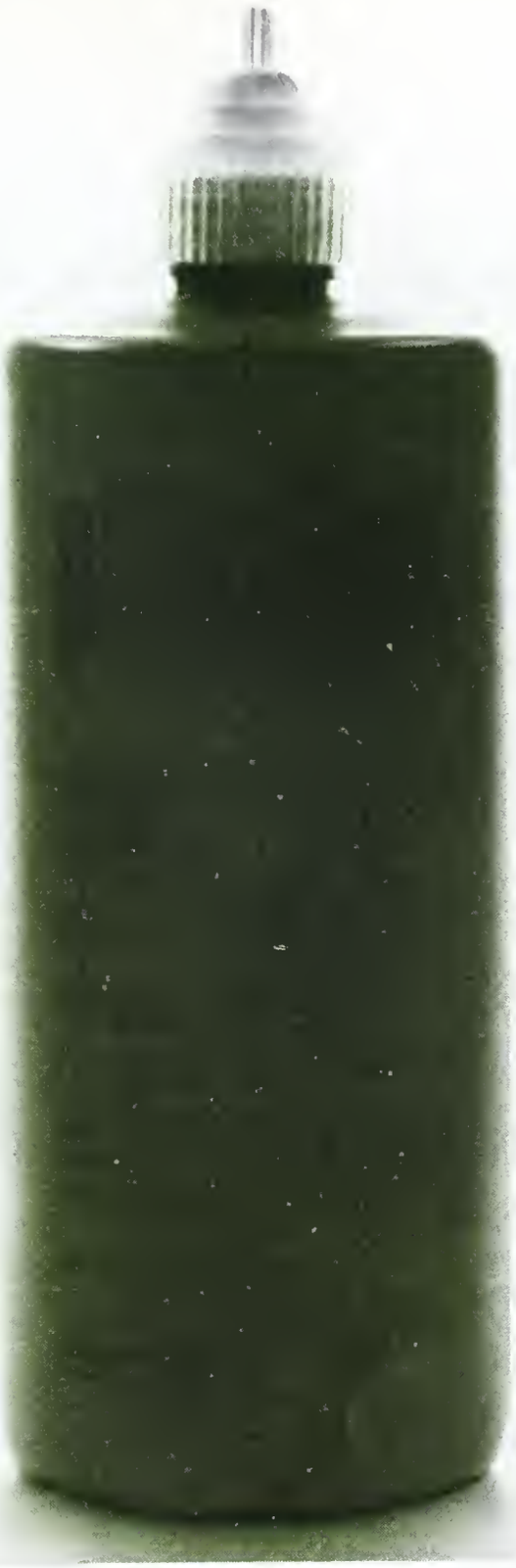
Office Supplies

Office Furniture

PH: 847-2086
for FREE
Speedy
Delivery Service
or
Visit our
Retail Store
at
3131 N. Nimitz Hwy.

OBLIQUE FILING
A suspended lateral filing method that can be installed anywhere.





the other baby bottle*

The little green bottle of pHisoHex is the second busiest bottle in most hospital nurseries.

Baby's first bath with pHisoHex, right in the delivery room, is an initial link in a chain of anti-Staph protection for the newborn. The chain can be kept unbroken throughout the infant's stay in the hospital nursery by giving him daily baths with pHisoHex and having nurses wash their hands with pHisoHex before and after handling each infant.

With every bath, pHisoHex creates a bacteriostatic film of potent hexachlorophene on skin. There it remains *between* baths to inhibit growth of microorganisms—especially Staph.

Mothers can maintain this antibacterial protection at home by bathing baby exclusively with pHisoHex.

And nonalkaline, hypoallergenic pHisoHex is kind to skin. Won't tend to dry or irritate, even when used frequently.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

...the nursery formula* that stops Staph from thriving on baby's skin

pHisoHex®

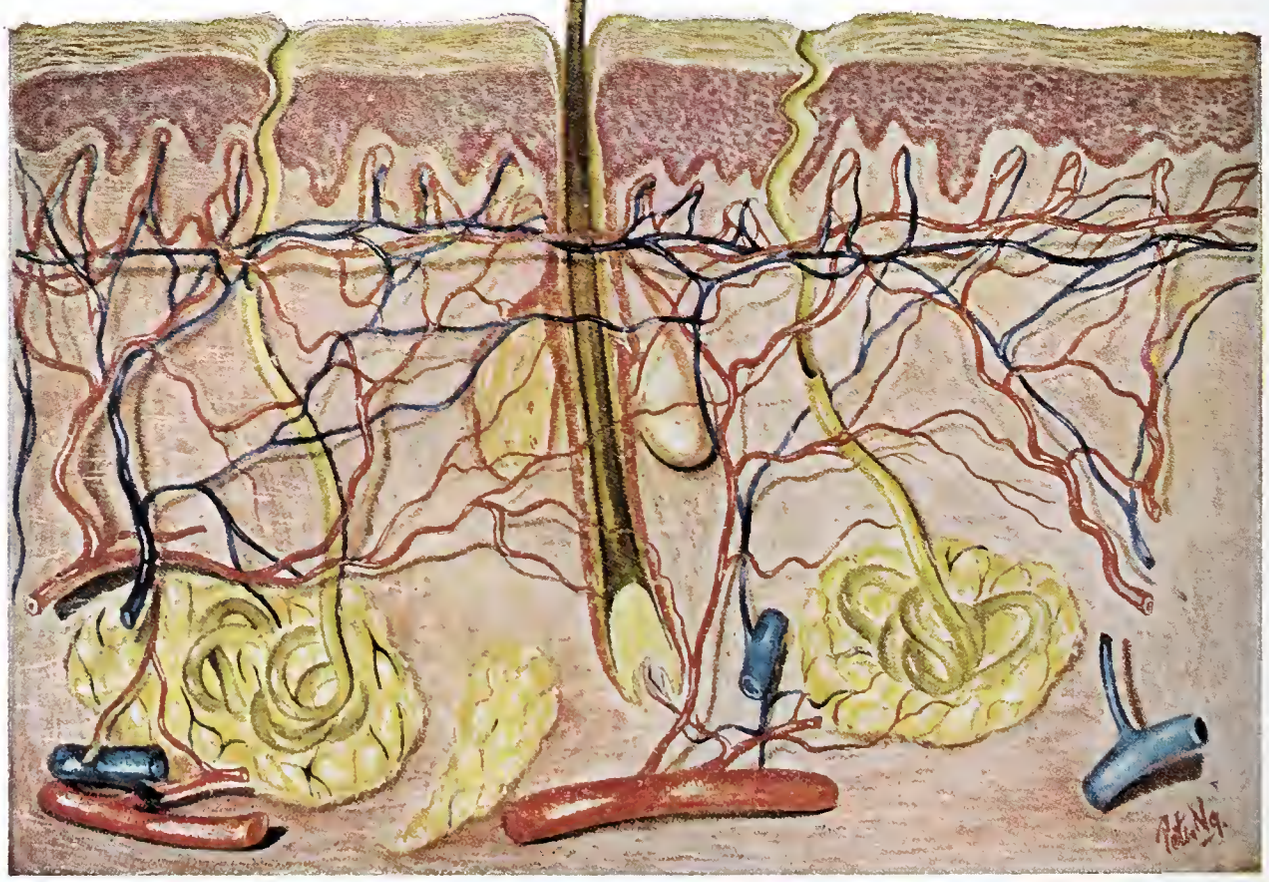
antibacterial skin cleanser with 3% hexachlorophene



(1432M)

*For external use only

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Hawaii Medical Ass'n *continued from 346*

Date of Use of RVS: Dr. Lowrey requested Council action for some definite course to follow in the use of the Relative Value Study. The Hawaii Medical Service Association has written to all physicians that HMSA will not be able to use the 1970 RVS until January 1, 1972. The Department of Social Services has requested HMSA to use the 1965 RVS. It was suggested that discussions be had with the ombudsman concerning the use of the 1970 Relative Value Study by the Department of Social Services.

ACTION:

It was voted to send a notice to HMA members that the Council has approved the use of the 1970 RVS as of March 1, 1971.

Legislative: Dr. Goto, Chairman for the Commission on Legislation, inquired whether the Council has any pressing matters which his Commission should consider for the coming year. One suggestion was the compulsory health insurance in the State.

Medical Education: The Council discussed the recommendation from Dr. Winfred Lee, Chairman for the Commission on Education and Research, to the House of Delegates "that the Hawaii Medical Association offer their assistance through the Medical Education Committee in future negotiations between the Medical School and hospitals to achieve the most ideal method of improving continual medical education and patient care." It was decided to write to Dr. Terence Rogers, Acting Dean, School of Medicine, and offer the assistance of the Medical Education Committee.

Employees' Per Diem:

ACTION:

It was voted to increase the present rate of $35 a day for employees' expenses to up to $50 a day for those who travel on HMA business.

MISCELLANEOUS BUSINESS

Date of Future Council Meetings: It was decided to schedule future Council meetings in July, September, mid-November, January, and April, with Fridays near the end of the month recommended as the best time.

Committee Actions that Involve HMA: In order that HMA does not get involved in possible controversial positions that may compromise the Association's effectiveness, the Council discussed commission and committee responsibilities.

ACTION:

It was voted to remind commissioners, committee chairmen, and committee members of their responsibilities and the limits of their authority.

The President informed the Council that the HMA officers plan on meeting every second and fourth Friday of each month from 7:30 to 9:30 a.m. Half of the commissioners will be asked to attend one meeting of the month, and the other half the second meeting to keep the officers abreast of committee actions.

Search Committee for Selection of Dean of the School of Medicine: Mr. Harlan Cleveland, University of Hawaii President, requested HMA assistance in forming a search committee for the selection of a permanent successor to Dr. Windsor Cutting, Dean of the School of Medicine. He asked for a list of ten doctors that HMA regards as suitable from whom they could select members of a search committee. Mr. Cleveland pointed out that Drs. Richard Mamiya, Satoru Nishijima, and Sharon Bintliff, by virtue of their extensive responsibilities in the School of Medicine, will automatically become members of this important group.

continued page 362

Trent

Medical Personnel Bureau

521-2948

LINDA LOUISE TRENT—*Executive Director*

"Serving the Personnel Needs of the Medical Profession"

Integrity — Efficiency — Courtesy

- HOSPITALS
- CLINICS
- EXTENDED CARE FACILITIES
- CONVALESCENT HOMES
- RESTORATIVE DEPT.'s — O.T.S.'s & P.T.'s
- MEDICAL AND DENTAL ASSISTANTS
- LABORATORY AND X-RAY TECHNICIANS
- RNs-LPNs-NURSES AIDES
- HOME CARE AIDES AND COMPANIONS
- OFFICE PERSONNEL
- MEDICAL SECRETARIES
- MEDICAL STENOGRAPHERS
- MEDICAL AND DENTAL RECEPTIONISTS
- MEDICAL RECORDS LIBRARIANS

Personnel carefully screened, evaluated and references verified.

24 HOUR SERVICE

521-2948

Hawaii Licensed Private Duty Female and Male Registered and Practical Nurses

1311 Kapiolani Blvd. — Room 407
Hawaiian Life Insurance Bldg.

Monday thru Friday — 8 A.M. to 5 P.M.

Closed Holidays

Hawaii Medical Ass'n *continued from 361*

ACTION:

It was voted to submit the following list of names to Mr. Cleveland: Herbert Y. H. Chinn (HMA President), William E. Iaconetti (HMA President Elect), Thomas P. Frissell (HCMS President), Winfred Y. Lee (HCMS President Elect), John J. Lowrey (HMA Past President), George Mills (HMA Past President), Theodore T. Tomita (HMA Past President), Robert H. Moser (Maui), Glenn Kokame (Chairman, HMA Medical Education Committee), and Frederick A. Dodge (President, Hawaii Academy of General Practice).

Drug Abuse: HMA's responsibilities in the proposed drug abuse council were discussed in view of a steering committee using HMA facilities and staff for their meetings to discuss future courses of action after this past Legislative session. This key group is composed of Dr. Hirobumi Uno (Special Assistant for Human Resources to the Governor), Dr. Robert Fisher (Department of Health), Reverend Seido Ogawa (State Law Enforcement & Juvenile Delinquency Agency), Mr. George Moorhead (Health & Community Services Council), and Dr. Charles Stewart (Chairman, HMA Ad Hoc Committee on Drug Abuse). It was agreed that since the drug abuse study was a mandate from the State Legislature, HMA facilities for meeting rooms will be made available; however, if this group requires financial assistance for future meetings, funds will be requested through the Governor's Office.

Names for a Directory of Federal Advisory Posts: A letter from AMA's Department of Field Service was reviewed relative to a directory of Federal advisory posts for physicians. AMA is requesting names of outstanding physicians who the Association feels is qualified to serve in key executive/administrative positions within the Federal Government and/or advisory positions to the various agencies.

ACTION:

It was voted to send names from the list of past and present HMA and HCMS presidents.

Report from the Woman's Auxiliary: Mrs. Sydney Fujita presented an impressive report on the activities of the Woman's Auxiliary. An effective defensive driving course was sponsored with participation from membership and community. Because of the enthusiastic response, the course may be repeated. A poison control poster contest was sponsored for school children. Six elementary schools participated. The AMA-ERF Calabash raised over $6,750 with more than 540 people attending. After organizing WASAMA (Women's Auxiliary to Students of the AMA), an Aloha Chapter was formed to help new interns and their wives to get acquainted with the community. In conjunction with this, they published a Kokua booklet on how to see Hawaii "on a shoe string." The Betty Crocker Ad Hoc Committee collected over 200,000 coupons, and will need 100,000 more. With these coupons they will purchase an audio-visual equipment for the Medical School. In addition to all these activities the ladies have been busy volunteering as drivers for the cancer cruiser, and completed nine new biographies and seventeen revisions for "In Memoriam."

ADJOURNMENT

The meeting adjourned at 11:35 P.M.

R. VARIAN SLOAN, M.D.
Secretary

MAY WE HELP YOU

TO HELP YOUR PATIENTS?

Complete Line – Orthopedic Supports
Artificial Limbs – Invalid Equipment

Certified Fitters

C. R. NEWTON CO. LTD.

1575 S. BERETANIA STREET
HONOLULU, HAWAII 96814
TELEPHONE 949-8389 OR 949-6757

Our "Angels"

Page

Amfac Distribution Company
Drug Department 244

Arch Laboratories
Dicarbosil 346

Ayerst Laboratories
Premarin 242, 243

Bess Office Products Center 358

Bio-Dynamics, Inc.
Unitest System 335

Bishop Computer Center 249

Bishop Trust Co., Ltd. 234

Brainard & Black, Ltd. 354

Burroughs Wellcome & Co. (USA), Inc.
Empirin Compound 245
Neosporin 360

Campbell Soup Company
Soup 273

Carnation Company 351

Central Pacific Bank 345

Coca-Cola Bottling Company of Honolulu, Inc. 348

Eurocars of Hawaii, Ltd. 248

Great Hawaiian Realty, Inc. 343

Hanalei Colony Resort 352

Hawaii Camera Co. 354

Hawaii Medical Service Association 240

Honolulu Orthopedic Supply 347

Island Nursing Home 356

La Pietra Development Corporation 290

Lederle Laboratories
Achrostatin V 275

Lilly, Eli, & Co.
Cordran Tape 250

Mead Johnson Laboratories
Prosobee 239

Medical Industries, Ltd. 357

Medical Placement Bureau 349

Page

Meditec Publications, Ltd. 339

M & S Distributors
Wonda-Chair 355

National Drug Company
Orenzyme/AVC Insert (between 244 & 245)
Tepanil/Quinamm Insert (between 240 & 241)

Newton, C. R., Co., Ltd. 362

O'Leary, Lydia, of Hawaii
Covermark 356

Optical Dispensers of Hawaii, Inc. 334

Physician's Ambulance Service, Inc. 347

Robins, A. H., Co., Inc.
Robinul 364, 365

Roche Laboratories
Efudex 230, 231
Librax 246, 247
Valium 368

Schuman Carriage Co. 353

Searle, G. D., & Co.
Demulen/Ovulen 366, 367

Security Diamond/Conrad Jewelers 341

Smith Kline & French Laboratories
Thorazine 289

Star-Bulletin Printing Company 348

Stuart Pharmaceuticals, Division of Atlas Chemical Industries, Inc.
Mylanta 232

Summers Prescription Shops 355

Teeny Tots' Footwear 350

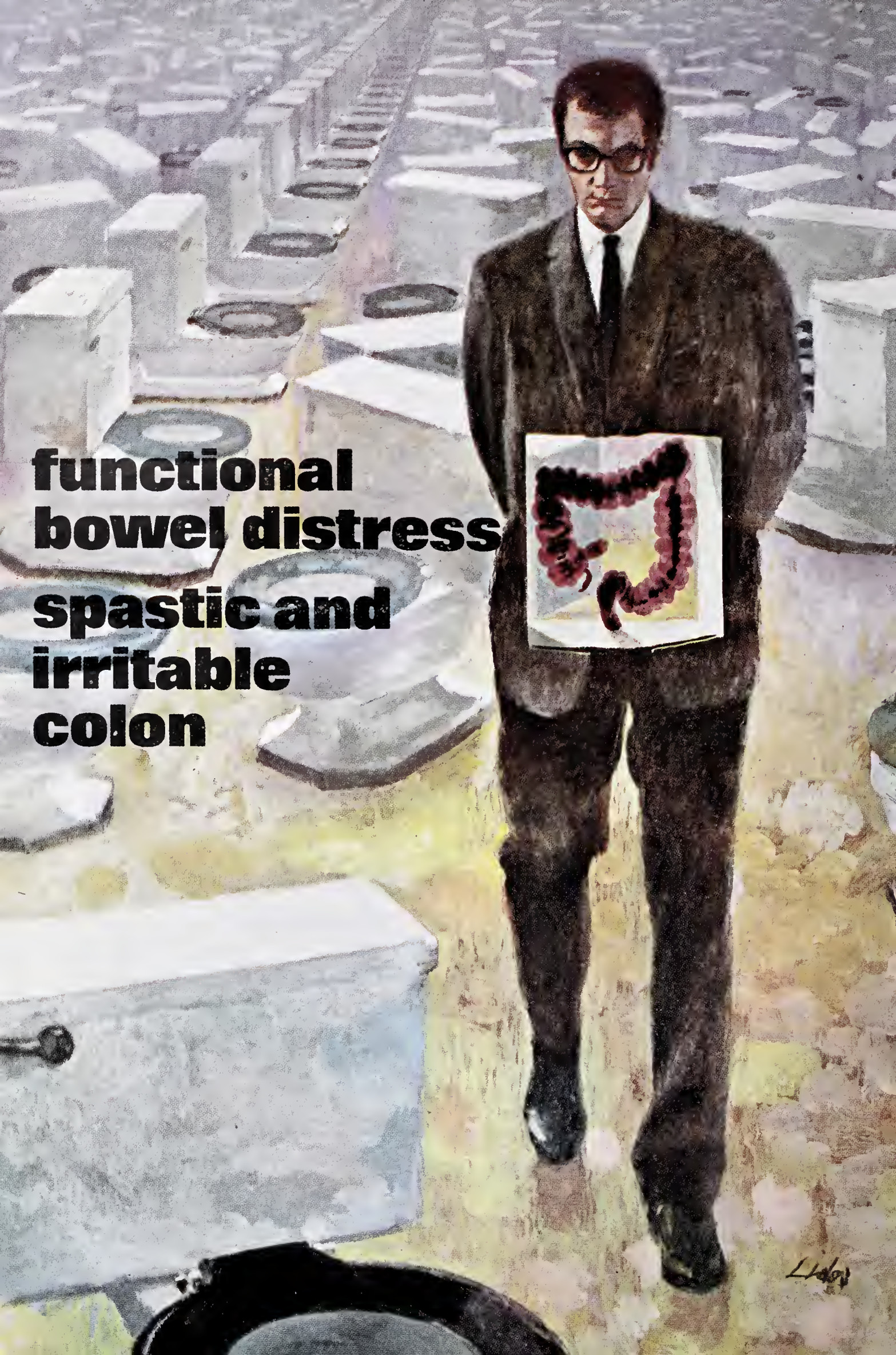
Trent Medical Personnel Bureau 361

Upjohn Company, The
E-Mycin 241

Velva Bergevin, Ltd. 349

Williams Mortuary 357

Winthrop Laboratories
Phisohex 359
Talwin Oral 236, 237, 238


functional
bowel distress
spastic and
irritable
colon

move up to "the Robinul response"

when lower G-I symptoms demand a potent synthetic antispasmodic

In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

Robinul® 2mg. Forte (glycopyrrolate)

■ **INDICATIONS** Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va.

A·H·ROBINS

An excerpt from the Searle series "The Ecology of Birth Control"*



The Unwanted Child & Birth Contro

Ten thousand battered children- a growing medical problem?

In his daily practice the physician witnesses the human suffering caused by uncontrolled fertility. Perhaps one of its most tragic effects is the unwanted child, who so often experiences parental rejection. The rejected child in a family may be neglected, nagged and severely punished. Sometimes he is criminally abused. Child abuse is common enough to have become a separate clinical entity: the "battered child" syndrome. Reliable statistics are difficult to obtain, but it has been estimated that in this country alone roughly 10,000 children are "battered" per year, and their number may be increasing.

A revealing picture of child abuse patterns is provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths wer of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

***For the complete brochure, and others in the seri as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcomin issues will be the history of birth control, the influen of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

MEDICAL CENTER LIBRARY
DEC 1 1971

SEPTEMBER / OCTOBER 1971

HAWAII MEDICAL JOURNAL

VOLUME 30 / NUMBER 5



Call it what you will, it may be premalignan

Before

3/29/67 Before therapy with 5%-FU cream. Patient P. T shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



ROCHE
Roche Laboratories
Division of Hoffmann-La Roche In
Nutley, N.J. 07110

ınd Efudex® (fluorouracil) 5% cream can resolve it.

ll it actinic, solar or senile keratoses, ıny regard it as "precancerous."[1,2]

ıical fluorouracil, considered by some dermatologists to be a major ance in the treatment of multiple solar keratoses,[3,4] offers the physi- n a relatively inexpensive alternative to cryosurgery, electrodesic- ion and cold knife surgery. Of the topical fluorouracils available, only ıdex offers 2% and 5% solution and 5% cream formulations—formula- ıs that have proved effective in the treatment of these mutliple lesions.

ıual duration of therapy, 2 to 4 weeks.

dies showed that with the 2% and 5% Efudex preparations, the usual ation of therapy was only 2 to 4 weeks.[5] Other studies with topical ɔrouracil revealed that when concentrations of less than 2% were d, significant numbers of lesions recurred.[6]

eats the lesions you can't see, too.

merous lesions, not apparent prior to 2% and 5% Efudex therapy, nifested themselves by definite reactions, while intervening skin ıained relatively unaffected.[5] The early eradication of these subclini- lesions (which may otherwise have undergone further progression) ɔbably accounts for the reduced incidence of future solar keratoses in ients treated with topical fluorouracil—especially with 5% centrations.[6]

ɔw to identify solar keratoses.

pically, the lesion—a flat or slightly elevated brown to red-brown ɔule—is dry, rough, adherent and sharply defined. Multiple lesions the rule.

edictable therapeutic response.

e response to a typical course of Efudex therapy is usually racteristic and predictable. After 3 or 4 days of treatment, erythema ins to appear in the area of keratoses. This is followed by a moderate ntense inflammatory response, scaling and occasionally moderate derness or pain. The height of this response generally occurs two eks after the start of therapy and then begins to subside as treatment topped. Within two weeks of discontinuing medication, the ammation is usually gone. Lesions that do not respond should biopsied.

erences: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, ne & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T., and Honeycutt, W. M.: eatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *rmaceutical Therapeutics in Dermatology*. Springfield, Ill., Charles C Thomas, 1968, 2. 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. ata on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and n, E.: *Cancer, 25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

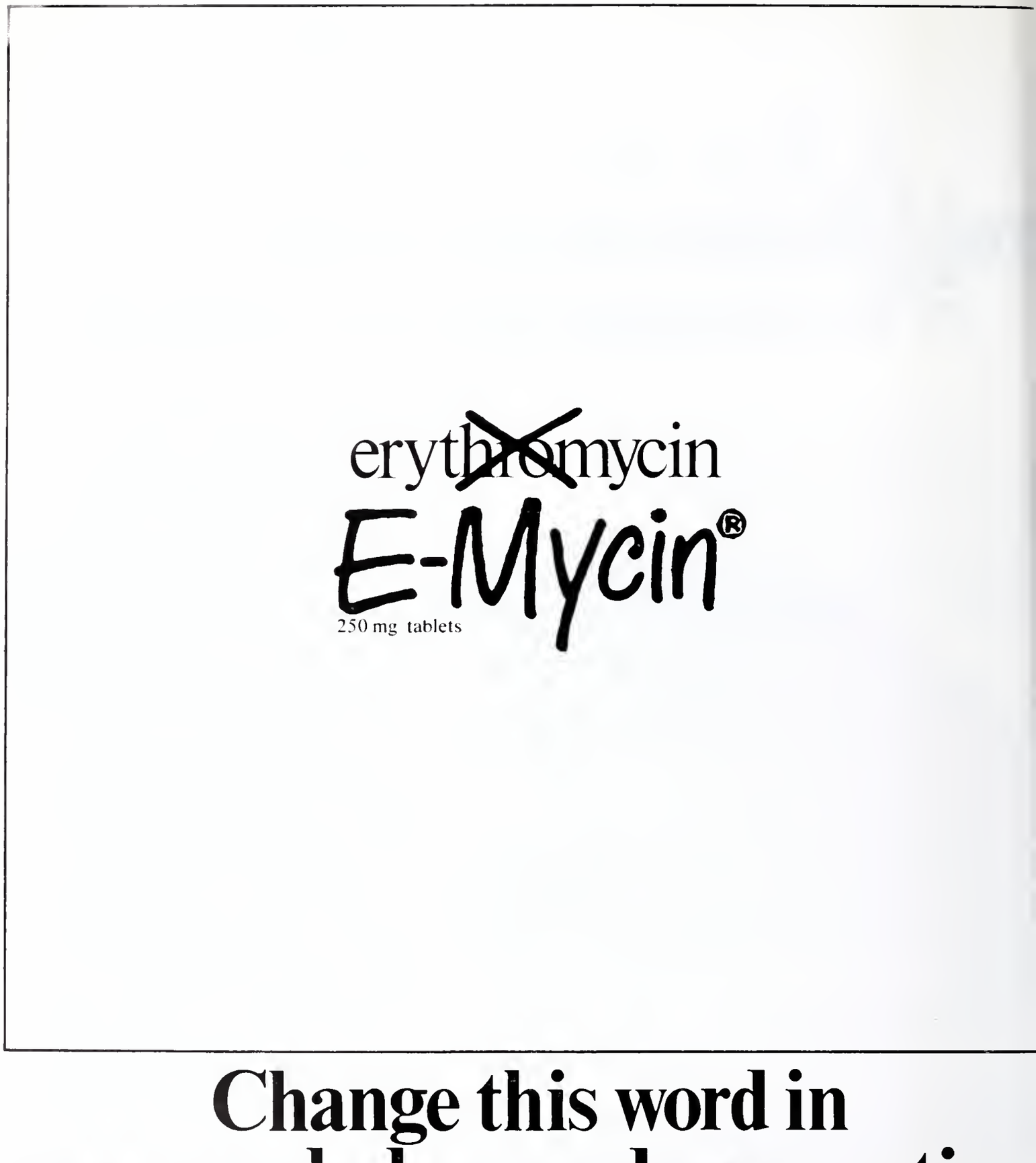


now

Efudex®

(fluorouracil)

cream/solution



Change this word in your vocabulary and your patient will get an Upjohn product and a low price.

E-Mycin® available in 250 mg tablets.

JA71-1585
© 1971 The Upjohn Company

The Upjohn Company
Kalamazoo, Michigan 49001

Upjohn

HAWAII MEDICAL JOURNAL

VOLUME 30, NUMBER 5

SEPTEMBER-OCTOBER, 1971

$6.00 A YEAR • $1.00 A COPY

Advertising Representative
LILITH JURRY
Phone 946-0053

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1971, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter. October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

Published Bi-Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, PAUL STEWARD
Associate Editor, MERYL H. HABER, M.D.
Contributing Editor, ROBERT H. MOSER, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.

The Hawaii Medical Association

Officers 1971

President • HERBERT Y. H. CHINN, *Honolulu*
President-Elect • WILLIAM E. IACONETTI, *Maui*
Past President • JOHN J. LOWREY, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • THOMAS P. FRISSELL, *Honolulu*

County Presidents

Hawaii County • VERNE ADAMS, *Pahala*
Honolulu County • THOMAS P. FRISSELL, *Honolulu*
Kauai County • CHARLES CUSTER, *Waimea*
Maui County • J. MARK B. SOWERS, *Wailuku*
Delegate to AMA • GEORGE H. MILLS, *Honolulu*
Alt. Delegate to AMA • THEODORE T. TOMITA, *Honolulu*

Councillors 1971

Maui • SAKAE UEHARA
Honolulu • GROVER H. BATTEN
Honolulu • WILLIAM W. L. DANG
Honolulu • H. WILLIAM GOEBERT, JR.
Hawaii • ED B. HELMS
Kauai • PETER KIM

Officers—County Societies—1971

HAWAII		HONOLULU
VERNE ADAMS •	President	• THOMAS FRISSELL
DEWITT H. SMITH •	Vice President	• WINFRED LEE
EDWARD BALLERINI •	Secretary	• WILLIAM DANG
ALLAN TAKASE •	Treasurer	• WILLIAM F. MOORE, JR.
MAUI		**KAUAI**
J. MARK B. SOWERS •	President	• CHARLES CUSTER
DENIS FU •	Vice President	• KATOK CHUANG
JOHN WITHERS •	{Secretary} {Treasurer}	• ROBERT BERRY

Physician, computerize thyself.

Do your billing by computer. You'll know where you stand, cash-wise, at all times.

You'll have a daily record of all charges and payments. Recapped weekly, monthly and annually to reveal which services are most productive and to indicate trends in your business.

You'll get out from under insurance paper work.

And be able to spot slow-paying patients immediately.

Conversion is easy... just a few hours, spent almost entirely in our offices.

Charges are based on how many patients you have per month.

And when hidden billing expenses are considered... typing, photocopying, filing, etc... our computers, staff and proven Accounts Receivable System* are yours for comparable cost at a great saving of your professional time.

Call us at 536-3771. And computerize thyself.



Bishop Computer Center

A division of Bishop Trust Co., Ltd / Bishop & King Streets

* Acquired from Data-Pac, Inc.

HAWAII MEDICAL JOURNAL

Contents

Volume 30, No. 5 • September-October, 1971

Articles

Alcohol and Drug Abuse in Hawaii 383
Walter B. Quisenberry, M.D., and Audrey Mertz, M.D.

Isolation of Virulent Paracolobactrum Aerogenoides Microorganisms from a Rat 386
Harry H. Higa, Ph.D., and George Q. L. Ching, B.S.

Anaphylactoid Purpura Associated with Smallpox Vaccination 388
K. Y. Wong, M.D.

L-DOPA and Parkinsonism 390
Michael M. Okihiro, M.D.

Aberrant Liver Tissue Presenting As Accessory Spleen on Spleen Scan Following Splenectomy 393
James J. Ball, M.D., Tamotsu Kanzaki, M.D., Carl H. Lum, M.D., Robert T. S. Jim, M.D., and Warren L. H. Wong, M.D.

Infectious Endocarditis 396
Robert H. Moser, M.D.

Life's Window—The Pupil 402
J. I. Frederick Reppun, M.D.

Editorials

Harry L. Arnold, Sr., M.D. 404

Features

Book Reviews 411

County Society Reports 418

Hawaii Academy of General Practice 409

Hawaii Medical Association 419

In Memoriam—Doctors of Hawaii 412

Inside HMA 408

Letters 381

New Members 416

Notes and News 414

President's Page 406

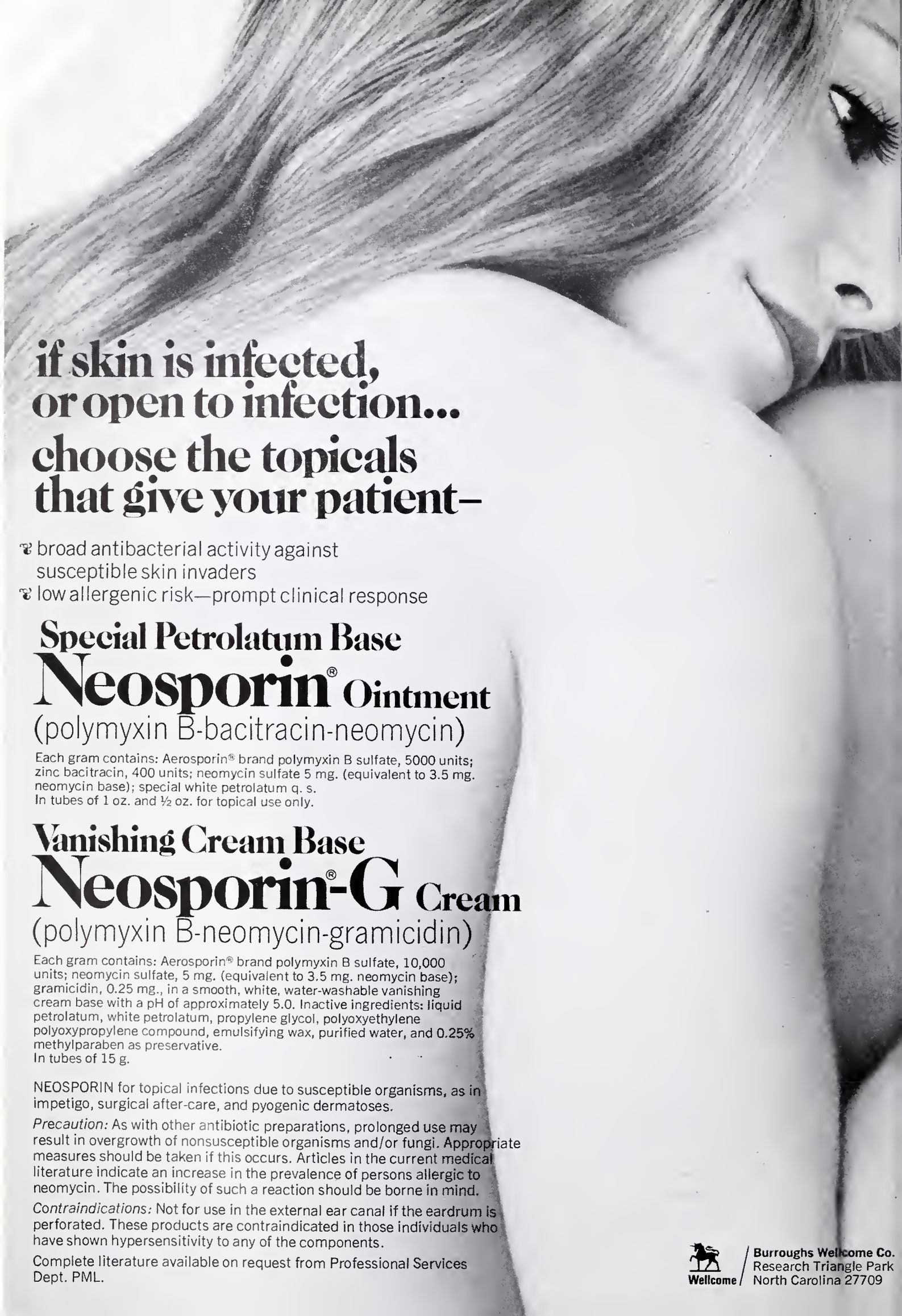
Slants and Angles 407

X-ray View Box 410

Hawaii Pharmacists' Bulletin

Third Party Prescription Programs 420

Cover: From the collection of Meryl H. Haber, M.D.



if skin is infected, or open to infection...

choose the topicals that give your patient–

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

Special Petrolatum Base
Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

Vanishing Cream Base
Neosporin®-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Controindicotions: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Worning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastraintestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-107/4/71/U S PATENT NO 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

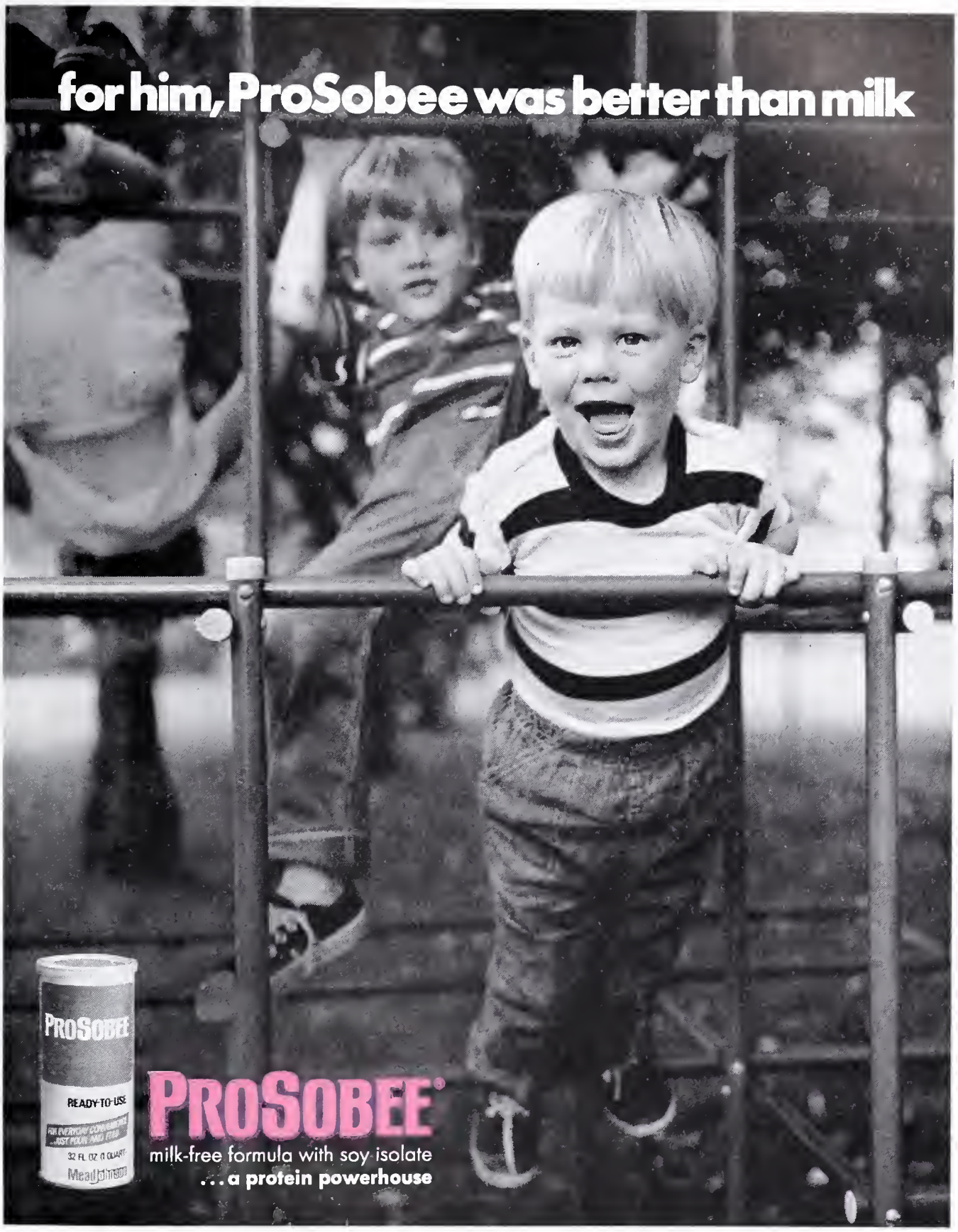
Prescribing Information—Composition: Each white, beveled, compressed tablet cantains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the preventian and treatment af nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrambophlebitis, arteriosclerosis and static faot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms af cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upan retiring. Where necessary, dasage may be increased ta ane tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON·MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Q103 2/71

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



For this ex-"problem feeder" there was an extra boost of protein that helped bring protein reserves up and helped keep them there ■ he received 25% or more protein from PROSOBEE than he would have from other soy isolate formulas ■ PROSOBEE has milk-like color, smoothness and flavor for greater acceptance ■ and now, convenient 32-fl. oz. PROSOBEE Ready-To-Use—no chance for mixing error. **For Hospital Use:** NURSETTE® disposable bottles, 4- and 8-fl. oz.; for the BENIFLEX® disposable nurser system, 32-fl. oz. cans.

Composition: 87% water, 3.9% sugar, 3.1% soy oil, 2.7% corn syrup solids, 2.7% soy protein isolate, 0.26% dicalcium phosphate, 0.26% potassium citrate, 0.10% lecithin, 0.05% calcium carbonate, 0.04% dibasic magnesium phosphate, 0.03% salt, 0.03% carrageenan, 0.03% guar gum, 0.02% DL-methionine, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, riboflavin, niacinamide, sodium iron pyrophosphate, potassium iodide, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, choline chloride, inositol, cupric sulfate, manganese sulfate and zinc sulfate.

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 77470

Mead Johnson LABORATORIES

now...

for the stable adult diabetic who needs higher doses of a reliable oral hypoglycemic...



new DBI®-TD 100 mg

(phenformin HCl)

timed-disintegration capsules

- a higher dosage strength for use in the overweight, maturity-onset diabetic if diet alone fails
- a biguanide...not a sulfonylurea
- new dosage flexibility
- low patient cost

new DBI®-TD 100 mg.
(phenformin HCl)
timed-disintegration capsules

lowers elevated blood sugar

Secondary to its blood sugar lowering effect, DBI-TD probably decreases insulin oversecretion and thus may help reduce lipogenesis and facilitate lipolysis. This may account for the clinically reported reduction in weight and lowering of serum cholesterol levels in the overweight and hypercholesteremic diabetic patient.

usually well tolerated

Mainly gastrointestinal side effects may occur. However, as with many drugs, you should keep in mind that higher dosages may increase the incidence. Hypoglycemic reactions are rare when DBI-TD is used alone.

to prescribe DBI®-TD (phenformin HCl) if diet alone fails specify

DBI-TD 50 mg. for the newly diagnosed overweight, stable adult diabetic
DBI-TD 100 mg. for the overweight, adult-onset diabetic who needs higher doses of a reliable oral hypoglycemic

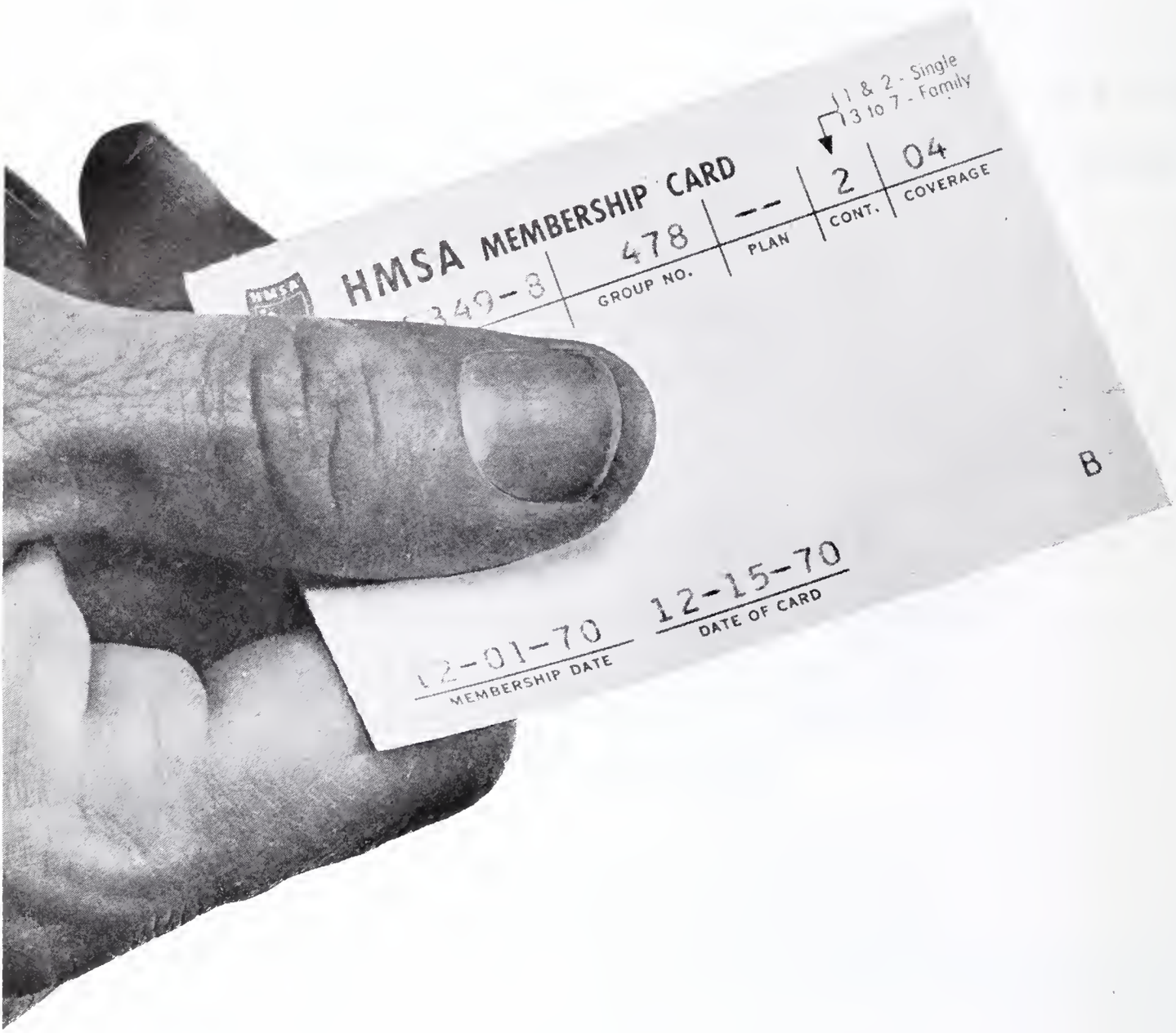
Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions: Starvation Ketosis,** which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS. **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period, particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 25 mg.-300 mg. daily. **How Supplied:** 50 mg. timed-disintegration capsules, bottles of 100 and 1000; 100 mg. timed-disintegration capsules, bottles of 100 and 500. **Also Available:** DBI tablets 25 mg., bottles of 100 and 1000.

USV PHARMACEUTICAL CORP., Tuckahoe, New York 10707

USV

"I'M FEELING
MUCH BETTER, DOCTOR."

"SO AM I."



HMSA is the "get-well card" that leaves you *both* feeling better. Offers patient and physician lasting relief from medical economic problems. Once again, March, July and November are individual enrollment months. An excellent time to remind unprotected patients about the benefits of belonging to this non-profit community organization. It's good for what ails them. And you.

HMSA

Hawaii-owned for Hawaii's own
HAWAII MEDICAL SERVICE ASSOCIATION
BLUE SHIELD PLAN FOR HAWAII
Member Western Conference of Prepaid Medical Service Plans

HONOLULU, 1504 Kapiolani Blvd., P. O. Box B60, Phone 944 2110
WAILUKU, MAUI P. O. Box 956, Phone 323 912
LIHUE, KAUAI P. O. Box 27, Phone 245 3393
HILO, HAWAII P. O. Box 1356, Phone 935-5441
KAILUA-KONA, HAWAII P. O. Box 1219, Phone 329-3030



vacation in a vial: the spasm reactors in your practice deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Side effects: Blurring of vision, dry mouth, difficu urination, and flushing or dryness of the skin may occur on highe dosage levels, rarely on usual dosage. Administer with caution t patients with incipient glaucoma or urinary bladder neck obstructio as in prostatic hypertrophy. Contraindicated in patients with acut glaucoma, advanced renal or hepatic disease or a hypersensitivity t any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS

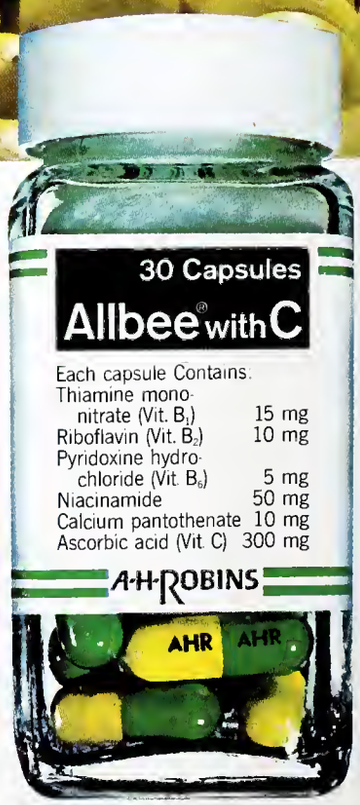


2 ways to provide a month's therapeutic supply of Vitamin C: 180 lemons or 30 Allbee® with C

As a source of ascorbic acid, the lemon really hits a high C (50 mg.). But your patient would still have to eat 180 lemons every month—6 a day—to get a therapeutic dose. And as the calypso singer puts it, "one hundred eighty lemons is impossible to eat." Fortunately, a bottle of 30 Allbee with C capsules (taken one capsule daily) supplies as much Vitamin C as all those lemons, plus full therapeutic amounts of the B-complex vitamins. For example, as much B_6 as two pounds of corn. Allbee with C is no lemon! This handy bottle of 30 capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS



Letters

To the Editor:

It is regretable that my first correspondence as a new member must be a complaint, but I must point out an error in the July/August issue of the HAWAII MEDICAL JOURNAL. Under the New Members section my photograph is printed over the caption of Harry L. Hinson, M.D.

I would particularly like to avoid a continuation of the same error in the publication of the annual roster.

Yours truly,
A. C. PEAT, M.D.

Our sincerest apology to both Drs. Peat and Hinson. For the record, we are reprinting both pictures below. —ED.



Alexander Peat, M.D.



Harry L. Hinson, M.D.

Call Us for
OPHTHALMIC INSTRUMENTS

GUILD OPTICIANS
OPTICAL DISPENSERS
of Hawaii, Inc.

532 PROFESSIONAL CENTER BLDG.
1481 SO. KING STREET — 955-6314

1133 BISHOP STREET
HONOLULU, HAWAII — 537-6570

1441 KAPIOLANI BLVD., SUITE 312
HONOLULU, HAWAII — 949-4795

103 PROFESSIONAL CENTER BLDG.
30 AULIKE STREET
KAILUA, HAWAII — 261-6030

Complete Contact Lens Service Available

Equipment Distributors for:

CARL ZEISS, INC., BAUSCH & LOMB, AMERICAN OPTICAL CO., SHURON, TITMUS, RELIANCE, WELCH ALLYN, KEELER AND LAWTON INSTRUMENTS.

it's the real thing

Enjoy Coca-Cola Trade-mark ®

COCA–COLA BOTTLING COMPANY
OF HONOLULU, INC.

MEDICAL PLACEMENT BUREAU and NURSES' REGISTRY

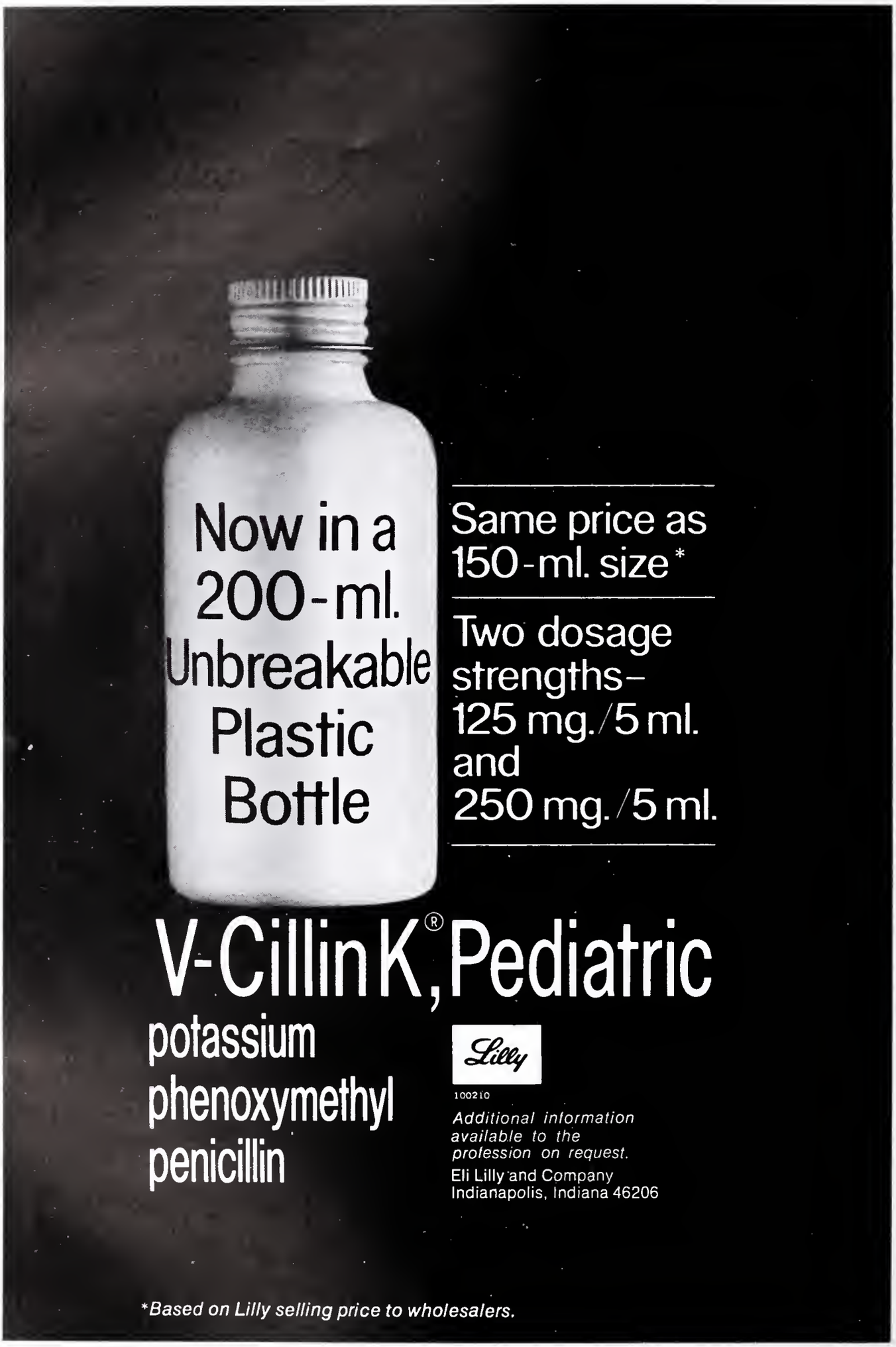
24 HOUR SERVICE

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

1415 Kalakaua Avenue **Suite 210**
Phone 949-1237


Now in a 200-ml. Unbreakable Plastic Bottle
Same price as 150-ml. size*
Two dosage strengths– 125 mg./5 ml. and 250 mg./5 ml.
V-Cillin K®, Pediatric
potassium phenoxymethyl penicillin
Lilly
100210
Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
*Based on Lilly selling price to wholesalers.

Public Health Report

Alcohol and Drug Abuse in Hawaii

WALTER B. QUISENBERRY, M.D.,* and
AUDREY MERTZ, M.D., *Honolulu*

HAWAII, like other states, has experienced an increase in drug abuse in recent years. We are told by visiting lecturers on the topic from California that we are behind them in drug abuse patterns. Some of our young visitors and new residents arriving from California and elsewhere bring drugs and new attitudes with them, but it takes some time for this impact to be fully felt.

Police arrest statistics show marked increases in recent years on all islands. The trend is still going up. The number of persons arrested for narcotics and dangerous drugs violations in the State went up from a total of 65 persons arrested in 1956 to a total of 1,628 in 1970.[1] This is 587 more arrests than in 1969. On Oahu, marijuana arrests went up from 443 in 1968 to 584 in 1969. Dangerous drug arrests went up from 87 to 171. Narcotic arrests rose from 37 to 118.

Arrests for glue and paint sniffing went from none in 1962 to 1,236 on Oahu in 1968. An additional group of young people who inhale fumes are handled as minors in need of supervision. The number of arrests for sniffing dropped to 651 in 1969 from the high level of 1968 and dropped again in 1970 to 451. It is not known whether this reflects an actual decrease in prevalence of sniffing, and, if so, to what factors it can be credited.

It is worthy of note, I believe, that last year we had 26 deaths due to taking of drugs throughout the islands. This is considered low in comparison to comparable areas of the Mainland U.S.A. All but one of these individuals was over age 20.[2] Barbiturates were most often implicated in these deaths.

JUVENILES STUDIED

Dr. Christopher Barthel, Department of Health psychologist assigned to the Family Court, studied juveniles seen in Family Court in 1968 for admitted use of drugs.[3] The sample contained 181 sniffers and 42 marijuana users. The ratio of boys to girls was 4 to 1, which is the usual ratio of all juveniles referred to Family Court.

Some significant differences were shown between the two sub-groups. Sniffers were younger, of larger families, and from lower income families than the marijuana users. The sniffers were predominantly Hawaiian, part-Hawaiian, and Oriental; marijuana users were predominantly Caucasian. The attitude of the parents of youngsters in the two groups was different. The parents of sniffers blame external factors, such as the influence of bad companions. The parents of marijuana users are likely to look at motivations within their children, such as curiosity, loneliness, insecurity, etc.

Dr. Barthel considers that the group of young people under study had the following reasons for using drugs:

Experimentation
Group pressure to try, and availability of drugs
Social relaxation
Self-enlightenment
Rebellion against parental authority
Escape from unpleasant feelings
Self-destruction

Some of the treatment efforts of agencies working with teenagers who sniff paint, take pills or smoke pot have focused, not on drug use, but on helping the young people to increase academic or vocational skills, to get along better with peers and with adults, and to work toward other constructive goals of their own choice. Improvement in these other areas of functioning usually leads to decreased use of drugs.

The Hawaii State Mental Hospital has had an increase in the past two years in admissions of drug users. This increase is largely in teenage patients who have had trouble from use of hallucinogens and other pills. Of 149 total admissions to Hawaii State Hospital in 1969 of drug users, 58 (39%) were in the age group 11-20.

In 1969 there were 39 admissions of users of hallucinogens. Thirty-three of these were male. Twenty-two, or 56%, were Caucasians.

We do not have information on the number of admissions to Hawaii State Hospital in 1970 for drug abuse, but it would probably not be any

* Director of Health, Hawaii State Department of Health.
Read before the Regional Meeting of the Hawaii Chapter of the American College of Physicians, April 5, 1971.
Received for publication May 25, 1971.

higher than in 1969 because of the development of an adolescent crisis team which treats as many as possible of the adolescent drug abusers at home.

METHADONE PROGRAM

In the past Hawaii State Hospital seldom admitted narcotic addicts. In 1969 there were 69 admissions of heroin addicts. This planned increase was caused by a methadone maintenance program for narcotic addicts. Addicts selected for the program by the John Howard Association were admitted to Hawaii State Hospital for withdrawal from heroin and were started on daily oral doses of the synthetic narcotic, methadone. This practice has now been changed and the addicts are usually not admitted to Hawaii State Hospital before being started on treatment. After two weeks they were discharged and reported to the Queen's Medical Center or to a recently opened branch at the Leeward Hospital daily for an oral dose of methadone. This synthetic satisfies the craving for heroin and frees the addict to concentrate on work, recreation and the rest of normal living instead of being obsessed with getting his next "fix." Usually about 45-50 addicts are in the program.

Addiction to narcotics was until the past few years a fairly stable situation in Hawaii. Of approximately 300 hard-core addicts in the State, about 60% of them have been found to be from out of State.[4] Some statistics regarding the addicts per capita population in Hawaii in comparison with some other jurisdictions as well as the United States as a whole might be of interest.[5]

United States—one addict per 3,500 persons
Puerto Rico—one addict per 250 persons
New York State—one addict per 750 persons
City & County of Honolulu—one addict per 2,102 persons
State of Hawaii—one addict per 2,566 persons

Many of the middle-aged, hard-core heroin addicts, long-time residents of Hawaii, are now active in the methadone program. The more recent applicants for the program are younger people, some of whom are rather recent arrivals in Hawaii. Often these people use other drugs as well as heroin.

ALCOHOL MOST ABUSED DRUG

The mind-affecting drug most commonly abused is still the old-fashioned one, alcohol. Advances have been made in the past two years in providing treatment and rehabilitation services for alcoholics.

The new mental health law, which became effective January 1, 1968,[6] includes persons habituated to the excessive use of drugs or alcohol along with mentally ill persons in all its provisions. These provisions include admission on a voluntary basis and admission on certificates of two physicians to all hospitals licensed as psychiatric facilities. Fourteen hospitals throughout the State are licensed as psychiatric facilities.

Act 6, which became effective January 1, 1969, repealed the public drunkenness statute and added to the mental health law provisions for handling intoxicated persons.[7] Hawaii is one of the three jurisdictions in the United States which have this law. The others are the State of Maryland and the District of Columbia. The purpose of this Act was to remove public drunkenness from eriminal offenses and to provide medical and rehabilitation services for people found drunk in public. Some people continue to be arrested for offenses committed while under the influence of aleohol, and intoxicated military personnel are still turned over to the Hawaiian Armed Services Police. But the others who are simply drunk in public are helped to get home or are taken to designated hospitals. There has been a marked increase in service to alcoholics at St. Francis Hospital, the Queen's Medical Center, and the Hawaii State Hospital.

DETOXIFICATION CENTER

In February 1970 a Detoxification Center was opened at the Salvation Army Facility on Iwilei Road in Honolulu.[8] From February 10 to November 16, 1970, approximately nine months, the Detoxification Center admitted 551 patients requiring detoxification from alcohol, an average of slightly more than 60 a month. Of the 551, only 60, or 11.1%, were women. Caucasians made up 80% (twice the proportion at risk) of the total, Hawaiians and part-Hawaiians 6.9%, Filipinos 4.4%, Japanese 3.8% (one-tenth the proportion at risk), and other ethnic groups 4.9%. There were no acknowledged Chinese admissions.

Current plans include consideration of the development of the capability of being able to provide detoxification services for abusers of a wide range of toxic substances.

In one year the Detoxification Center has provided detoxification services for approximately 750 of our citizens—members of our community who heretofore had been treated as criminals or whose needs were not being attended to at all. In addition, these services have been performed without any serious consequences, a considerable accomplishment when one considers the usual extremely poor medical condition of this type of patient.

SURVEY OF PHYSICIANS

Recently 393 physicians throughout the State replied to a questionnaire about drug abuse sent out by the Hawaii Medical Association.[9] Of these, 143 had seen drug abuse problems within the last 60 days, with the following substances involved:

224 alcohol
105 hallucinogens
97 barbiturates
94 marijuana

68 Inhalants—paint or glue
64 amphetamines

The great majority of the doctors responding felt they had someone in the area to consult with about these cases, but that they need more referral services for acute and chronic drug abuse problems.

SUPPORT OF GOVERNOR AND LEGISLATURE

We have been fortunate in the support we have received from our Governor and the Legislature. Examples of recent legislation enacted by the Legislature and signed into law by our Governor are:

1. The basic Hawaii State Drug Abuse Act which became law on June 8, 1967. It provides special controls for depressant and stimulant drugs as well as other drugs which have a potential for abuse.[10] Hawaii is one of the first states to have such an Act.
2. The Legislature last year passed what is known as Act 65 for the purpose of appropriating funds for support of a methadone experimental program which I mentioned earlier.[11]
3. Other acts which have been passed appropriated funds for the State to contract with the county enforcement agencies and nonprofit organizations for education and rehabilitation projects relating to drug abuse and also provided funds for the University of Hawaii to develop a study of state programs for rehabilitation of persons addicted to or in imminent danger of becoming addicted to narcotics.[12]

Supplementing these acts, we now have a joint Federal and State agreement which was signed in June 1970 in order to assure the ultimate in cooperation between the State and Federal authorities in combatting drug abuse.

THE HAWAII COMMITTEE ON DRUG ABUSE

The Hawaii Committee on Drug Abuse was mandated by the 1970 Hawaii State Legislature in Senate Concurrent Resolution 75.[13] The Hawaii Medical Association was requested to take a leadership role in the formation of the Hawaii committee. The problems involving substance misuse in our society are very deeply woven into the present American way of life. They are widespread and include almost every age group and culture. They are complex, involved, and characterized by wide variability in use and abuse. Thus, the Committee found itself with a very formidable task.

The Committee was formed with as wide a representation of the community as possible. Yet, formal membership was limited to 12 persons from the Hawaii Medical Association, University of Hawaii School of Medicine, Hawaii Youth Correctional Facility, Honolulu Police Department, State Department of Health, the Hawaii State Senate, the Hawaii House of Representatives, State Attorney General's Department, Health and Community Services Council of Hawaii, and the State Law Enforcement and Juvenile Delinquency Planning Agency.

Committee members met on a regularly scheduled and frequent basis for several months, their work being culminated by the publication of an official report titled "Report of the Hawaii Committee on Drug Abuse" dated January, 1971. This report advocated establishment of a Hawaii State Commission on Dangerous Substances to continue to plan and coordinate efforts to more successfully combat the problems related to abuse of toxic substances.

The recommendations of this committee are under consideration by the legislature now and may be implemented by legislative acts.

CONCLUSION

Some dimensions of the alcohol and drug abuse problems and control programs in Hawaii have been given. The mind-affecting drugs getting people into difficulty most frequently are alcohol, hallucinogens, marijuana, inhalants, barbiturates, and amphetamines.

The most encouraging aspect of our program to control alcohol and drug abuse in Hawaii is that attention is being given now more than ever before to prevention, education, and rehabilitation, as well as to law enforcement. Because of the nature of the problem, the work is discouraging, but we are sure our approach will pay off in time.

REFERENCES

1. Statistics supplied by private communication with various County Police Departments in the State, 1970.
2. Office of Research and Statistics, Hawaii State Health Department.
3. Barthel CE: Drug Use Among Family Court Youth in Hawaii, May 1969 (unpublished).
4. Information supplied by the various County Police Departments in the State, 1969.
5. Report of Food and Drug Branch, State Department of Health, Honolulu, Hawaii, 1970.
6. Chapter 334, Mental Health, Mental Illness, Drug Addiction and Alcoholism, Hawaii Revised Statutes.
7. Act 6 (S.B. 78), 1968, A Bill for an Act Relating to Mental Health, Mental Illness, Drug Addiction and Alcoholism; Amending Chapter 81, Revised Laws of Hawaii 1955; Repealing Section 278-1, Revised Laws of Hawaii 1955.
8. Subsidy section of the Appropriations Act of Session Laws of Hawaii 1969 provided $105,000 for Salvation Army Center—"Provided that the subsidy for the center, shall be disbursed by the Department of Health for the direct costs of the short-term care of alcoholics, and shall not be expended for any administrative overhead of the center."
 Report on Implementation of Contract with Salvation Army Center for Short-Term Care of Alcoholics, December 29, 1969.
9. Hawaii Medical Association Physician Survey conducted by Ad Hoc Drug Committee, January 1970.
10. Hawaii Drug Abuse Act, Session Laws of Hawaii 1967, Act 286, p. 448.
11. Hawaii Drug Abuse Act, Regular Session 1970, Volume 1, Act 65.
12. Hawaii Drug Abuse Act, Act 127, Relating to drug abuse control, Volume 1, approved June 19, 1970 by Governor John A. Burns. Act 156, University of Hawaii to undertake a study to develop a state program for rehabilitation of persons addicted to, or in imminent danger of becoming addicted to, narcotics, approved June 23, 1970 by Governor Burns, Volume II.
13. Hawaii State Senate Concurrent Resolution 75, 1970.

Isolation of Virulent Paracolobactrum Aerogenoides Microorganisms from a Rat

Paracolobactrum aerogenoides can cause disease in rats.

HARRY H. HIGA, Ph.D., and GEORGE Q. L. CHING, B.S., *Honolulu*

Paracolobactrum aerogenoides does not commonly occur in a virulent invasive form. This report shows that the rat can be systemically afflicted by this organism, which causes gastroenteritis and urinary infections in man.

PARACOLOBACTRUM aerogenoides belongs to the paracolon group and occupies a position intermediate to the coliforms and the salmonella.[1] Its habitats include the intestinal tracts of man and animals and it appears to be associated with diarrheal disease.[2] These organisms have been encountered occasionally in cultures from fecal specimens in cases of human gastroenteritis.[3, 4] They have also been found in cases of human urinary tract infections.[5]

The authors wish to report the isolation of P. aerogenoides from an infected rat to further indicate the significance of the rat as a carrier or disseminator of virulent organisms other than the organisms of such diseases as bubonic plague, leptospirosis, typhus, and salmonellosis.[6] In the course of routine postmortem examinations, an adult Rattus rattus female rat, weighing 140 grams, snap trapped in the Kaneohe district of Oahu, Hawaii, showed the following macroscopic examination results. The lungs were hemorrhagic, the liver slightly enlarged, and the intestines were distended and discolored. The spleen and lymph nodes appeared normal. Contact smear of the liver showed the presence of a moderate amount of gram negative microbial rods measuring approximatcly 0.5 by 3.0 microns.

The liver and spleen were aseptically removed and homogenized in a Waring blender to a 25% suspension, using sterile physiological saline as the diluent. One milliliter of this blended material was injected intraperitoneally into an adult guinea pig (2.5 lbs), which died in 24 hours. Necropsy of the guinca pig showed considerable hemorrhage throughout the subcutaneous tissue of the abdomen as well as exudate in both pleural and peritoneal cavities. Contact smears of the liver and spleen as well as direct smears of the exudates showed moderate amounts of gram negative rods (about 0.5 by 3 microns).

The organisms from these tissues (guinea pig liver and spleen) were cultured in Difco brain-heart infusion broth. One-half ml of a 24-hour culture was injected intraperitoneally into an adult guinca pig (2.7 lbs), which died in 24 hours. Five adult white laboratory mice (av. wt.—35 grams) were each inoculated intraperitoneally with 0.5-ml quantities and all died within 24 hours.

These virulent, gram-negative, motile, straight rods, occurring singly were subjected to cultural studies and identified as Paracolobactrum aerogenoides. The results of cultural studies are given in Table 1.

The paracolon organisms are characterized by a consistently delayed fermentation of lactose and occasionally lactose is not fermented.[7] P. aerogenoides is also characterized by the production of acetylmethylcarbinol.[8]

Vector Control Branch, State of Hawaii, Department of Health. Laboratories Branch, State of Hawaii, Department of Health.
Received for publication November 20, 1970.

TABLE 1.—*Cultural characteristics of Paracolobactrum aerogenoides.*

GROWTH ON AGAR		ACTION ON CARBOHYDRATE SUBSTANCES		ACTION ON PROTEIN SUBSTANCES		TEST FOR OTHER SUBSTANCES	
Salmonella-shigella	4+	glucose	AG	gelatin	—7	acetyl-methyl-carbinol	+
MacConkey	4+	maltose	AG	litmus acid milk	coag.		
EMB	4+	sucrose	AG	urea	—	indole	—
Blood	4+	lactose	—7			NO_3	+
non-(hemolytic)		mannitol	AG			KCN	+
		Salicin	AG			H_2S	—
		adonitol	—7			lysine decarb-oxylation	+
		dulcitol	—7				
		inositol	AG			phenyl-alanine deaminase	—
		glycerol	AG				
		sorbitol	AG			catalase	+
		raffinose	AG			oxidase	—
		triple sugar iron agar dextrose lactose saccharose	—/AG				
		10% lactose	+				

Legend: (+) positive; (—) negative; (AG) acid, gas; (—7) negative after 7 days; —/AG negative slant with acid and gas in butt; (coag.) coagulation.

REFERENCES

1. Thompson LR: *Microbiology and Epidemiology*, Fourth Edition, Philadelphia: W. B. Saunders Co., 1958.
2. Smith AL: *Principles of Microbiology*, Fifth Edition, St. Louis: C. V. Mosby Co., 1965.
3. Burdon KL: *Textbook of Microbiology*, Fourth Edition, New York: The McMillan Co., 1958.
4. Chakrabarty AN, et al: Observations on paracolons isolated from cases of acute gastroenteritis. *J Indian Med Assn* 41:251-254, 1963.
5. Lystad A: An unusual *Paracolobactrum aerogenoides* as the cause of nosocomial urinary tract infection. *Acta Path Microbiol Scand* 54:400-411, 1962.
6. Higa HH: Correspondence. *Am J Trop Med & Hyg* 18:821, 1969.
7. Breed RS, Murray EGD, Smith NR: *Bergey's Manual of Determinative Bacteriology*, Seventh Edition, Baltimore: The Williams & Wilkins Co., 1957.
8. Borman EK, Stuart CA, Wheeler CM: Taxonomy of the family Enterobacteriaceae. *J Bact* 48:351-367, 1944.

Anaphylactoid Purpura Associated with Smallpox Vaccination

Smallpox vaccination can cause purpura.

K. Y. WONG, M.D.,* *Honolulu*

Major and serious complications of smallpox vaccination have been well documented.[1, 2] *These include encephalitis, autoinoculation, vaccinia necrosum, eczema vaccinatum and generalized vaccinia. Other cutaneous complications are few and anaphylactoid purpura occurs infrequently after smallpox vaccination. There have been scanty reports in the British and the European literature.*[3, 4] *It is the purpose of this communication to report such an unusual complication after primary smallpox vaccination.*



FIG. 1.—*Crusted stage of the primary vaccination.*



FIG. 2.—*Distribution of purpura over the lower extremities.*

REPORT OF A CASE

AN EIGHT-MONTH old girl was admitted to the Kauikeolani Children's Hospital because of swelling of both lower extremities with a purpuric rash. She had been in perfectly good health and there was no antecedent infection before the present episode. There was no history of contact or ingestion of chemicals or drugs. No personal or family history of bleeding tendency was obtained. The patient had had a primary smallpox vaccination 16 days prior to admission (Fig. 1). Physical examination did not reveal any other focus of infection. Liver and spleen were not palpable. There was no lymphadenopathy. Both ankles were swollen. Purpuric lesions, some confluent and forming ecchymotic areas, were present over both lower extremities (Fig. 2). Two small purpuric spots were noted behind the right ear; otherwise the face, the trunk, and the upper extremities were free of lesions.

From the Kauikeolani Children's Hospital, Honolulu, Hawaii.
* Present address: The Mount Sinai Hospital, 5th Avenue and 100th Street, New York, New York 10029.
Received for publication November 20, 1970.

Laboratory data revealed hemoglobin of 11.8 gm%, hematocrit 37%, and a white blood cell count of 21,400 per cu. mm. with 3% stab forms, 41% segmented forms, 2% eosinophils, 52% lymphocytes and 2% monocytes. Platelet count was 557,000 per cu. mm. There was no microangiopathic change in the morphology of the red blood cells. Fibrinogen level was normal. Urinalysis was also normal. Cerebrospinal fluid was clear, with 3 mononuclear cells per mm,[3] protein of 13 mg%, and sugar 62 mg%. Culture of the CSF was sterile. Throat culture yielded normal flora, and blood culture was negative.

The patient never appeared toxemic. A few fresh petechiae appeared over the arms shortly after admission. On the following day, there was no further development of the skin lesions and the existing purpuric areas began to fade. Ankle swellings had subsided three days later, the patient was discharged in excellent condition with almost complete resolution of the purpura.

COMMENT

Cutaneous complications other than direct spread from the inoculation site are uncommon after smallpox vaccination. A generalized maculopapular rash of short duration has been described to oecur about one week after vaccination.[1] Secondary bacterial infection is related to personal hygiene and the environment. More severe reactions include bullous erythematous reaction (Stevens-Johnson syndrome), erythema multiforme and toxic epidermal necrolysis.[2] Purpuric eruption after smallpox vaccination is very unusual. Thrombocytopenic purpura may develop after primary or re-vaccination and it has been thought to be an allergic phenomenon.[5] A child with dormant idiopathic thrombocytopenic purpura had recrudescence three days after primary vaccination.[2]

Nonthrombocytopenic or anaphylactoid purpura occurs infrequently as a complication.[3, 4] It may also follow other immunizations like diphtheria vaccine and both the Salk and the Sabin vaccines.[4] The patient described in this report did not have thrombocytopenia and there was no evidence of sepsis or disseminated intravascular coagulation. The ankle swellings also favored the diagnosis of anaphylactoid purpura. However, anaphylactoid purpura is unusual under one year of age.[6] Its occurrence at 16 days after primary vaccination suggests some relationship to the vaccination rather than mere coincidence. Because of the rarity of this complication, it is difficult to evaluate the exact pathogenic mechanism. Anaphylactoid purpura can occur from 3 to 20 days after vaccination.[3] It has been suggested that it is the result of the direct toxic action of the vaccine on the capillaries if it occurs within a few days after vaccination. An immunoallergic mechanism has been proposed if there is a time lapse for the formation of an antigen-antibody complex which then acts on the capillaries.[4]

SUMMARY

An 8-month-old girl with anaphylactoid purpura complicating primary smallpox vaccination was described. The clinical course was benign. This complication is rare and the exact pathogenic mechanism is still unknown.

REFERENCES

1. Neff JM, Levine RH, Lane JM, et al: Complications of smallpox vaccination, United States 1963. II. Results obtained by four statewide surveys. *Pediatrics* 39:916, 1967.
2. Lane JM, Ruben FL, Neff JM, et al: Complications of smallpox vaccination, 1968. National surveillance in the United States. *New Eng J Med* 281:1201, 1969.
3. Waddington E, Bray PT, Evans AD, et al: Cutaneous complications of mass vaccination against smallpox in South Wales 1962. *Trans St John's Hosp Derm Soc* 50:22, 1964.
4. Giordano S, Cordone G: Sindrome di Schönlein-Henoch postvaccinica. *Minerva Pediat* 17:59, 1965.
5. Meindersma TE, deVries SI: Thrombocytopenic purpura after smallpox vaccination. *Britt Med J* 1:226, 1962.
6. Allen DM, Diamond LK, Howell DA: Anaphylactoid purpura in children (Schönlein-Henoch syndrome). *Amer J Dis Child* 99:833, 1960.

L-DOPA and Parkinsonism

L-DOPA is effective in parkinsonism.

MICHAEL M. OKIHIRO, M.D., *Honolulu*

The initial observations by Cotzias et al[1] that dioxyphenyl alanine (DOPA) in large oral doses was effective for the treatment of parkinsonism, has been amply confirmed.[2, 3, 4] For the neurologist l-DOPA has proven to be a most exciting drug for the treatment of a neurological disorder which afflicts an estimated 1 million-plus victims in the United States alone. This drug has recently been released by the Food and Drug Administration and is now available for the practitioner.

NOTWITHSTANDING the glowing reports of its successes, l-DOPA is not the easiest drug to use. It has many side effects, and all patients who use l-DOPA will experience untoward effects at some time. After using this drug for well over a year we would like to present our experience in the hope that this may be of some help to other practitioners who plan to use l-DOPA.

METHODS

The Northwestern University disability scale[5] was used to evaluate each patient before starting l-DOPA therapy. The scale divides the patient's problems into five functional areas: (1) walking; (2) personal hygiene; (3) dressing; (4) eating and feeding; and (5) speaking. Each of these subscales is arbitrarily assigned 20 points, so that a total of 100 points is possible in a functionally normal patient. This evaluation was repeated at the end of six to eight weeks and periodically thereafter. The percentage of improvement was calculated for each patient as follows:

$$\frac{\text{Final score—pretreatment score}}{\text{100—pretreatment score}} \times 100 = \%\ \text{improvement}$$

Movies were taken before treatment and after six to eight weeks, when the maintenance dose of l-DOPA was reached, and periodically thereafter. The dynamic changes that occur as the patient improves with l-DOPA were frequently much more easily demonstrable in movies than by other methods of measurement.

The following laboratory tests were performed once weekly for the first month, then once every two weeks for the next month, once every month for the next three months and then once every two months: CBC, urinalysis, SMA-12 (calcium, phosphorus, sugar, BUN, uric acid, albumin, total protein, bilirubin, alkaline phosphatase, SGOT, LDH and cholesterol). An EKG was done on all patients initially, but repeated only if any cardiovascular symptoms were reported.

Initially a few patients were hospitalized to start l-DOPA therapy, but it was soon found that the great majority of patients can be treated safely as outpatients. At the present time we usually see our patients at least once a week for the first month, once every two weeks for the next month, once a month up to the sixth month and then once every two months.

From the Department of Neurology, Straub Clinic.
Received for publication Dec. 1, 1970.

L-DOPA comes in three sizes: 100 mg, 250 mg and 500 mg capsules or tablets. The 100 mg size is not of much practical use. The majority of patients can be started on 250 mg four times daily and the total daily dosage can be increased by 250 to 500 mg every three days or so. Most patients do well taking the medication after meals and at bedtime. When a single dose exceeds 1.25 to 1.5 gram, however, many patients experience side effects, so that it is often best to give some of the drug between meals.

Generally, the maintenance dosage is a compromise at a level which produces maximal improvement with tolerable side effects. For most of our patients this is between three and six grams per day.

RESULTS

Between August 1969 and August 1970, a total of 47 patients with Parkinson's disease have been tried on l-DOPA. The followup period ranges from three to fifteen months. There were 31 men and 17 women. The youngest patient was 37 and the oldest 77 years. The racial extraction was 10 Caucasians and 37 Orientals (Japanese 30, Chinese 3, Korean 2, Filipino 2).

Twelve of the patients (26%) showed more than 75% improvement, 22 (47%) showed better than 50% improvement and eight (15%) achieved less.

Six patients discontinued medication for various reasons. One patient felt he had achieved no significant improvement. Two quit because of side effects (depression in one and "weakness" in another). L-DOPA was terminated in one patient after a cerebral hemorrhage and in another after a myocardial infarction. One patient died while on l-DOPA. This was a woman with severe Parkinson's who began to show significant improvement after a month of treatment. She was found dead by her son, who had left her only an hour or so earlier, and a coroner's examination revealed that she had aspirated her dinner.

As noted previously, all patients experienced some side effects from time to time. Gastrointestinal symptoms were experienced by most patients. Nausea and vomiting were more apt to occur when l-DOPA was taken on an empty stomach or when a dose of more than 1.25 to 1.5 gram was given at one time.

A few patients have experienced significant weight loss of 15 to 20 pounds due to anorexia. However, with time this symptom disappeared and the patients have either maintained their weight after the initial loss or regained their former weight.

Many patients experienced lowering of blood pressure on l-DOPA, so that at the present time hypertensive patients are taken off their antihypertensive drugs when l-DOPA is started. The blood pressure tends to return to pretreatment levels over a period of months, but most patients have not yet had to go back on antihypertensive drugs. Orthostatic hypotension has been a problem in two patients.

Paroxysmal tachycardia was a rare complaint, but one patient developed paroxysmal auricular fibrillation whenever he took more than one gram of l-DOPA as a single dose. This has been effectively treated with propranolol.

Sleep disturbances are not infrequent. Insomnia occurs fairly commonly but has not been a major problem. Vivid, recurring nightmares and nocturnal hallucinations are sometimes reported by relatives. The aphrodisiac effect that l-DOPA was reported to have some months ago has not been observed very often.

We have had one patient discontinue l-DOPA because of a severe depressive reaction, but we have also treated patients who have had serious emotional disorders in the past without experiencing any exacerbations on l-DOPA. These include a patient who attempted suicide only months before, a severe obsessive-compulsive neurotic woman, and a chronic ambulatory schizophrenic.

The most interesting side effect of l-DOPA is the production of abnormal involuntary movements. These movement disorders are quite variable. They most commonly involve facial and oral musculature, with grimacing, mouthing movements or rhythmic bobbing of the lower jaw or entire head. However, any muscle can be involved, and choreiform, athetoid, and myoclonic movements have been seen. At least eight of our patients have experienced these abnormal involuntary movements.

Most parkinsonian patients have been on anticholinergic drugs, such as Artane and Cogentin, when they come to us for l-DOPA. We used to discontinue these drugs once the patients began to show favorable responses to l-DOPA, but we found that this often had a deleterious effect and some patients felt much worse despite good doses of l-DOPA. Furthermore, the gastrointestinal side

effects of l-DOPA seemed less in patients on anticholinergic drugs, so that we now generally have the patients continue them.

No significant abnormalities were noted in the battery of laboratory studies which were carried out. Two patients had transient, mild leukopenia and one patient had a drop in hemoglobin to 10.5 gm for which no cause was found, but this has since corrected itself.

DISCUSSION

The effectiveness of l-DOPA in the treatment of parkinsonism has been confirmed many times over. Yahr *et al*[3] have reported at least 20% improvement in 91% of their long-term patients. McDowell[4] reports a 13% treatment failure rate. Despite these optimistic figures, however, it is still impossible to predict the degree and kind of improvement in each individual case.

The primary limiting factor in l-DOPA therapy is the patient's ability or inability to tolerate an effective daily dose.

Gastrointestinal side-effects are the most common, but Cotzias[6] says that "we do not have limiting problems with nausea, vomiting, or anorexia." Slow gradual increases in dosages, post-prandial administration, and multiple small doses reduced the frequency and severity of these symptoms. Yahr *et al*[3] have noted that patients maintained on conventionally used anti-Parkinson drugs seem to have less trouble with these symptoms because of their anticholinergic effect.

The hypotensive effect of l-DOPA is usually mild and well tolerated by most patients. It tends to decrease with time. Application of elastic stocking or bandages and administration of two grams of sodium chloride a day has been advocated by Yahr.[7] In one of our patients with troublesome orthostatic hypotension, we used Florinef for a few weeks, and this seemed to prevent further syncopal episodes.

Barbeau *et al*[8] noted that parkinsonian patients tend to have low plasma renin activity, and that it fell to unmeasurable amounts when l-DOPA was given. Although the blood pressure tends to return to pre-dopa levels after a few months, plasma renin activity remains low so that other homeostatic mechanisms must come into play.[9]

The abnormal involuntary movements produced by l-DOPA tend to occur in patients who have had good relief of their parkinsonian symptoms. The movement disorder seems to be dependent on total daily dosage (tending to occur with larger doses) and duration of l-DOPA administration (more apt to occur as l-DOPA is continued). For unknown reasons, the particular type of abnormal movement is characteristic of the individual patient. Fortunately, the movement disorders are always reversible as the total daily dosage is decreased, but unfortunately, the parkinsonian symptoms reappear with the decreased dosage. Many patients will tolerate the milder abnormal movements, and for the difficult patient it may be possible to titrate out this side effect with pyridoxin.[10]

SUMMARY

Forty-seven patients with Parkinson's disease were treated with l-DOPA between August, 1969 and August, 1970. Seventy-three percent obtained good to excellent results, with better than 50% improvement.

The treatment program can be safely initiated and carried on as an outpatient procedure. Although practically all of the patients experienced side effects to l-DOPA, these side effects can usually be effectively handled. The older anti-Parkinson drugs such as Artane, Cogentin, etc., appear to have a beneficial effect which l-DOPA sometimes cannot completely supplant, so that we presently keep many patients on them.

There is no question that l-DOPA is the drug of choice for the treatment of Parkinson's disease.

ACKNOWLEDGMENTS

I wish to thank Dr. Morton Berk for allowing me to take part in his studies on l-DOPA, and Hoffman-LaRoche, Inc. who supplied the l-DOPA for our study.

REFERENCES

1. Cotzia GC, Van Woert MH and Schiffer LM: Aromatic Amino Acids and Modification of Parkinsonism, *New Eng J Med* 276:374-379, 1967.
2. Cotzias GC, Papavasiliou PS and Gellene R: Modification of Parkinsonism—Chronic Treatment with L-DOPA, *New Eng J Med* 280:337-345, 1969.
3. Yahr MD, Duvoisin RC, Schear MJ, Barrett RE and Hoehn, MM: Treatment of Parkinsonism with Levodopa, *Arch Neuro* 21:343-354, 1969.
4. McDowell FH: Treatment Failures with L-Dopa. L-Dopa and Parkinsonism. Edited by Barbeau A and McDowell FH. F. A. Davis Company, Philadelphia, Pa., 1970. pp. 9-10.
5. Canter GJ, de La Torre R and Mier M: A Method of Evaluating Disability in Patients with Parkinson's Disease, *J Nerv Ment Dis* 133:143-147, 1961.
6. Cotzias GC: Limiting Factors in the Treatment with Dopa. pp. 3-5.
7. Yahr MD in general discussion of papers on Clinic Effects of L-Dopa Upon Blood pressure. pp. 265-268.
8. Barbeau A, Gillo-Joffroy L, Boucher R, Nowaczynski W and Genest Jr: Renin-aldosterone System in Parkinson's Disease. *Science* 165:291, 1969.
9. Barbeau A: Dopamine and Blood pressure Regulation. *Clin Res* 17:634, 1969.

Aberrant Liver Tissue Presenting As Accessory Spleen on Spleen Scan Following Splenectomy

All that scans in the left upper quadrant is not necessarily an accessory spleen.

JAMES J. BALL, M.D., TAMOTSU KANZAKI, M.D., CARL H. LUM, M.D., ROBERT T. S. JIM, M.D., and WARREN L. H. WONG, M.D., *Honolulu*

A young woman underwent splenectomy for idiopathic thrombocytopenic purpura with good initial results. Careful search for accessory spleen at the operation was made but none could be found; however, the patient had a relapse of her thrombocytopenia one month after the splenectomy. A liver and spleen scan using ^{99m}Tc-labeled colloidal sulfur performed three months after the splenectomy demonstrated what appeared to be a normal spleen in the usual location. The patient required an excessive amount of corticoid to control her hematologic disorder and subsequently underwent a second operation for removal of accessory splenic tissue. At surgery, the organ appearing on the liver-spleen scan in the posterior aspect of the left upper quadrant of the abdomen proved to be an elongated extension of the liver folded back on itself, and no accessory spleen could be found.

SPLENECTOMY still plays a major role in the management of idiopathic thrombocytopenic purpura. The indications for splenectomy in the management of idiopathic thrombocytopenic purpura include those cases who have not had a spontaneous remission, and those who need an excessive dose of corticoid for control.[1] Secondary failure or relapse following splenectomy with initial good response may be due to presence of accessory splenic tissue.[2]

Proof of the role of the functioning accessory spleen as a specific cause of recurrent thrombocytopenic purpura following splenectomy depends upon demonstrating lasting improvement in the hematologic disorder after removal of the accessory splenic tissue. The ability to scan the spleen with radioistopes is a relatively recent adjunct to the study of the spleen in relation to various disease states. Although several radionuclides in varying forms have been used for scanning of the spleen, it was not until technetium sulfide ^{99m}Tc, became generally available that this procedure became relatively simple and effective.[3]

^{99m}Tc has the desirable medical and physical property of emitting a "clean," relatively low-energy gamma ray, well-suited for detection and scanning. It emits no particulate radiation, and has a short physical and biologic half-life. The combination of the ^{99m}Tc with colloidal sulfur assures uniform particle size with selective removal of the isotope from the circulation by the liver, spleen, and bone marrow.

The known relationship between idiopathic thrombocytopenic purpura and abnormalities of the spleen and the relative ease of imaging the spleen by radioisotope scanning with ^{99m}Tc-labeled sulfur colloid make this procedure a logical

From the Departments of Nuclear Medicine, Surgery, and Medicine, Queen's Medical Center, Honolulu, Hawaii 96813.
Received for publication February 5, 1971.

method to evaluate the effectiveness and completeness of splenectomy in this disease. The case report which is presented is an example of idiopathic thrombocytopenic purpura treated by splenectomy with only temporary benefit to the hematologic abnormalities. An apparent accessory spleen was subsequently demonstrated by spleen scanning and laparotomy was performed to remove this spleen; however, the tissue proved to be aberrant liver instead.

CASE REPORT

The patient was a thirty-four year old housewife of Japanese ancestry who first visited her physician in February, 1970 because of a one-year history of generalized pruritus with easy bruising after scratching or other minor trauma. She gave no history of excessive bleeding from cuts, prolonged menstrual bleeding or epistaxis. She had no known allergies to medication, food, or plants and had not been exposed to any known toxic substances, chemicals, or insecticides. She had been taking no medications.

She had never had a blood transfusion. There was no known family history of bleeding disorders or blood disease. She underwent a subtotal thyroidectomy in 1960 for hyperthyroidism and took antithyroid drugs and Lugol's solution preoperatively. She had had three uncomplicated full-term pregnancies. A sister had diabetes. Her review of systems was otherwise noncontributory.

She had multiple small ecchymotic areas on her trunk. She had no petechiae on her buccal mucosa or around her ankles. There was no apparent enlargement of her liver or spleen and there was no adenopathy or tenderness to palpation over her bones. Examination of her head, neck, heart, lungs, abdomen, and extremities was otherwise normal.

Her initial hematologic studies showed a normal hematocrit, hemoglobin, red and white blood cell count and differential count. Her platelet count was 92,000/mm^3. A urinalysis was normal as were the serum electrolytes, proteins, calcium, phosphate, bilirubin, glucose, cholesterol, SGOT, LDH, triglycerides, uric acid, PBI and T3 resin uptake. A VDRL test and LE antiagglutination test were negative.

Repeat platelet counts on three occasions during the following six weeks showed a progressive decrease to 34,000/mm^3. Clot retraction was poor and her Rumpel-Leede test was positive. A bone marrow biopsy performed six weeks after her initial visit to her physician demonstrated mildly hypercellular bone marrow with increased megakaryocytes, consistent with idiopathic thrombocytopenic purpura.

In April 1970, she underwent a splenectomy at Queen's Medical Center. She had not been given any corticoids prior to her surgery. At surgery, the spleen appeared to be normal in appearance and in location, and careful search for accessory splenic tissue was unrewarding. Microscopic examination of the spleen did not reveal any abnormalities. The patient did very well postoperatively: clot retraction became normal five days after splenectomy and her platelet count rose to 130,000/mm^3 by the eighth postoperative day. She had no complications from her surgery and was discharged on no medication.

Her platelet count increased to a maximum of 150,000/mm^3 three weeks after surgery. However, it then began to decrease and she was given up to 60 mgm of prednisone per day for the next two months with virtually no effect. She was then given 6.75 mgm of dexamethasone per day with improvement in her platelet count but with the concurrent production of moderate hyperadrenocorticism.

The possibility of an accessory spleen as a cause of the relapse of her disease was considered and a liver and "spleen" scan using ^{99m}Tc-labeled sulfur colloid was performed (Fig. 1). This study was done in the anterior, posterior and lateral projections, as well as in the anterior and posterior oblique views. The organ concentrating the isotope in the posterior portion of the left upper quadrant had all the isotope-scanning features of a spleen, with the usual contour and size and location.

On the basis of this study and because of the relapse of the thrombocytopenic purpura following splenectomy and the requirement of excessive doses of corticoids, the patient was readmitted to the hospital and an exploratory laparotomy was performed in August, 1970. At this second operation it was found that the organ in the left upper quadrant of the abdomen was an elongated extension of the liver which had folded back upon itself. Careful search was again made in the splenic bed, the omentum, and in the region of the pancreas without locating anything which could reasonably be considered to be composed of splenic tissue.

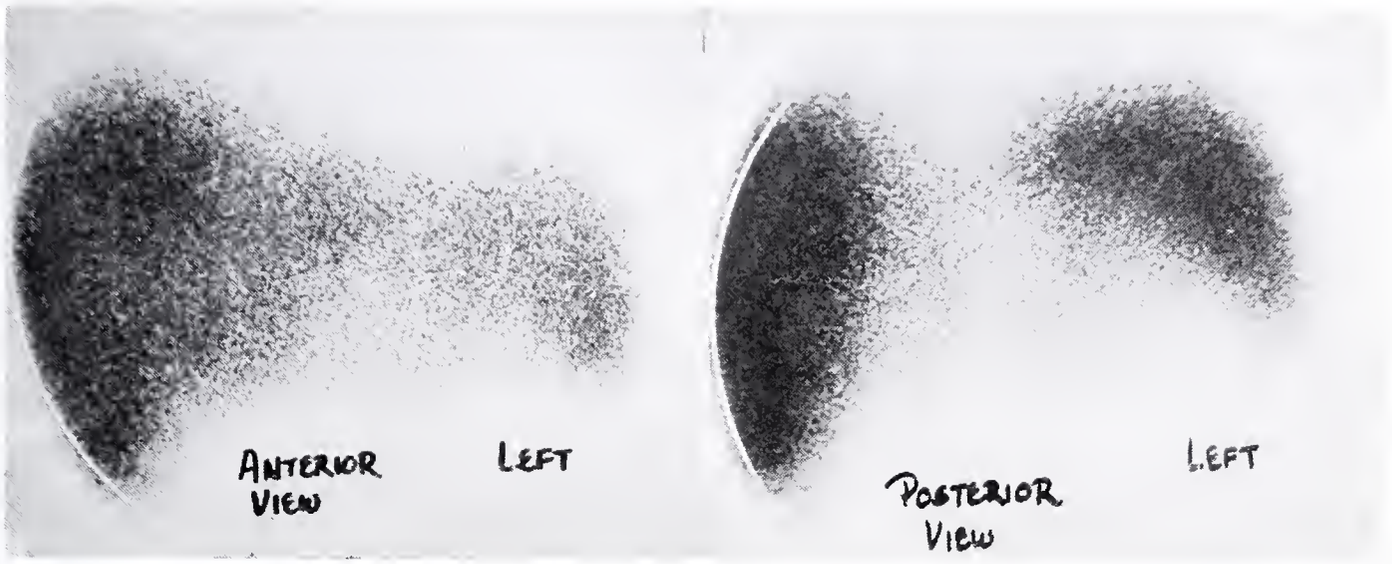


FIGURE 1.

The operation was terminated without removal of any tissue, and the patient had an uneventful post operative course. She was continued on the dexamethasone and discharged home to be followed further as an outpatient.

DISCUSSION

This case report is presented to caution against the impression that all organs that appear to be spleen when utilizing technetium sulfide ^{99m}Tc, may not in fact be spleen.

The use of this radionuclide has greatly simplified routine scanning of the spleen in the last few years, and it is only too easy to rely on this method in searching for symptomatic, accessory splenic tissue. The original method of spleen scanning consisted of tagging the red blood cells with sodium chromate ^{51}Cr and then damaging them with heat. When properly done, this would produce a spleen scan of acceptable quality without the complicating concentration of the tagged red blood cells by the reticuloendothelial system of the liver.[4]

Considering the rather high incidence of secondary failure following splenectomy for idiopathic thrombocytopenic purpura, and the close though not necessarily causal relationship between functioning splenic tissue and this disease, it would seem reasonable to utilize all investigative methods available in its management. Preoperative spleen scanning on a routine basis should have something to offer for later comparison if splenic regrowth becomes a consideration. Also, the more tedious method using heat-treated red blood cells tagged with ^{51}Cr instead of the technetium sulfide ^{99m}Tc would avoid the confusion which can be caused by a liver of unusual configuration, as reported in this article. The use of Indium ^{133}In-labeled colloid has the same disadvantages for this particular application of spleen scanning as does the ^{99m}Tc-sulfur colloid material.[5] Much the same objections can be raised for the use of BMHP, a mercury-labeled compound which is concentrated by the spleen but also accumulates in the liver and kidneys.[6]

The suggestion is made that preoperative splenic scans be performed if splenectomy is contemplated for this disease and that the older method using ^{51}Cr-labeled red blood cells be used as the scanning agent instead of the ^{99m}Tc-labeled sulfur colloid.

NONPROPRIETARY AND TRADE NAMES OF DRUGS

Technetium Sulfide Tc 99m—Tesuloid, Colloscan-99m; Sodium Chromate Cr 51—Chromitope Sodium, Rachromate-51; BMPH—bromo-1-mercuri-2-hydroxypropane; Prednisone—Deltadome, Deltasone, Meticorten, Prednisone; Dexamethasone—Decadron, Gammacorten, Hexadrol.

REFERENCES

1. Wintrobe MM: Clinical Hematology 5th ed., Philadelphia: Lea & Febiger, 835, 1961.
2. Morrison M, Lederer M, Fradkin WZ: Accessory spleens: their significance in essential thrombocytopenic purpura hemorrhagica, *Amer J Med Sci* 176:672-680, 1928.
3. Petasnick JP, Gottschalk A: Spleen scinti-photography with technetium-99m sulfur colloid and the gamma ray scintillation camera, *J Nuclear Med* 7:733-739, 1966.
4. Johnson PM, Wood EH, Mooring SL: Splenic scintillation scanning, *Amer J Roentgenol* 86:757-767, 1961.
5. Sorsdahl OA, Bruno FP, Williams CM: Spleen scanning with indium 133m labeled colloid, *Amer J Roentgenol* 104:674-677, 1968.
6. Croll MH, Brady LW, Brodsky I, et al: A new agent for splenic scanning: BMHP, Radiology 84:492-495, 1965.

Infectious Endocarditis

ROBERT H. MOSER, M.D., *Wailuku, Maui*

The essence of viability in clinical medicine is the ability to keep pace with new developments. "Old" diseases take on new guises—as epitomized by infectious endocarditis. Changes have occurred in clinical profile, concepts of pathogenesis, etiology, epidemiology and treatment.

The "new faces" of infectious endocarditis can emerge as subtle progressive nibbling or rapid ferocious destruction of heart valves. Potential cure is at hand if one is alert to the problem. If you have not learned more about "acute" and "subacute" infectious endocarditis than you knew as a house officer—then you are out of step with the times.

Neither acute nor subacute infectious endocarditis has to be bacterial, and they aren't the same kind of disease, either, that they were a decade or two ago. Times are changing!

IT HAS BEEN said that the essence of viability in clinical medicine is the ability to remain elastic, the capability to select and assimilate what is pertinent of the new information and to modify and update our knowledge, continuously. There are countless examples of this dynamic phenomenon in medicine, but nowhere is it more dramatically demonstrated than in the evolution of infectious endocarditis.

The point is—were we obliged to depend on the criteria that most of us learned in our years as house officers—to suggest and establish the diagnosis of infectious endocarditis, it is a fair bet that we would miss more than we make today.

Received for publication January 26, 1971.

CHANGING CLINICAL CRITERIA

In "subacute bacterial endocarditis" (SBE), the classic elements of fever; murmur; petechiae; embolism with infarction of spleen, kidney, or brain; and positive blood cultures, are still quite helpful. But all too often in the modern era, we are denied one or several of these criteria, and new ones have arisen to take their place.

For example, there are cases of SBE reported with no murmurs during the period of active infection, and about 20% of patients will have consistently negative blood cultures. There are several reasons for this, and we will discuss them later.

Louis Weinstein[1] once stated that in his early studies with SBE about three-fourths of patients suffered splenic infarcts with rapidly expanding splenamegaly, or renal infarct with loin pain and hematuria. But he had not seen a clinically manifest renal or splenic infarct in the past 15 years: a most remarkable turnabout. However, when patients die of SBE and are seen at autopsy, one can still find infarcts in these areas, but they are much smaller than the ones we used to see.

There are rare patients with proven SBE who have no fever. This may occur in someone who has received suboptimal antimicrobial therapy, or in those with significant azotemia, or others with a serious central nervous system lesion.

Neuropsychiatric complications occur in 25 to 50% of patients with bacterial endocarditis,[1] and Jones *et al*,[2] report that in more than half of these, the CNS lesion is one of the major presenting manifestations of bacterial endocarditis. Thus if

you encounter sudden hemiplegia in a young person, beware infectious endocarditis.

Many patients with SBE now present with backache: fever, anemia, murmur, and backache of a nonspecific nature not related to renal infarction. This was again demonstrated in a recent *New England Journal of Medicine* CPC.[3]

BLOOD CULTURES

The explanations for these changes in clinical spectrum vary from obvious to obscure. Negative blood cultures may result from previously inadequate dose or improper selection of an antibiotic, faulty blood culture technique, or renal insufficiency. But the most striking reason is prolonged duration of disease. In SBE, the longer the diagnosis is delayed, the more likely one will be denied positive blood cultures. The explanation is that the immune mechanism has had a chance to marshal its forces, and bactericidal antibodies are developed. Organisms continue to be shed from valve cusps, but they are killed before they complete the long journey from valves to peripheral veins, where the blood sampling is done.

The technique of blood culturing is a critical point also. It has been taught for many years that the ideal time to culture is *not* at the peak of fever, but approximately two hours earlier, just at the time of the initial elevation from the baseline. This can be ascertained by hourly monitoring of rectal temperatures in a salicylate-free state. As soon as the temperature rises 0.2 to 0.4° blood cultures should be taken. The theory is that at the zenith of fever the cellular and humoral defenses have already been mobilized, and bacterial destruction is occurring. The yield will be poor.

But Williams *et al*[4] have challenged this concept; they contend that timing is of little importance, since the bacteremia of endocarditis is constant.

The great debate about how many blood cultures to take seems to have been resolved. Six cultures taken at 15- to 30-minute intervals should suffice. Take more than this, and you begin to add tenths of a percent to your yield; it is not worth the added effort.

Another point stressed by Weinstein[1] is that enough blood must be taken to insure reasonable sampling of the intermittent bacteremia. He recommends 10 ml placed into 100 ml of medium, to dilute antibodies existing in the blood. Others suggest a 1:20 dilution.[4] Portions of the blood sample should be incubated in a carbon dioxide atmosphere and in media to support aerobic and anaerobic growth. Anaerobic cultures are mandatory to detect the 10 to 15% of microaerophilic streptococci, and another 5 to 10% of enterococci (Streptococcus fecalis). Special media must be used if fungi or rickettsia are suspected. And, of course, they must be incubated two to three weeks. If the patient has received treatment with penicillin, methicillin, or oxacillin, penicillinase must be added to the culture media. PABA will neutralize sulfa drugs, and metallic salts of cystine will neutralize tetracyclines.

SBE VERSUS ABE

At this juncture it might be worthwhile to discuss for a moment the distinction between SBE and acute bacterial endocarditis (ABE). For practical purposes they could almost be regarded as different diseases, with as many dissimilarities as similarities in pathophysiology, clinical manifestations, treatment, and prognosis.

As you know, SBE is usually engrafted on valves deformed by either acquired or congenital disease. In SBE the causative organisms, Streptococcus viridans and Staphylococcus albus (which we will comment upon later) are less virulent than those involved in ABE. And this is the focal point of a major pathogenetic difference. SBE is characterized by antibody formation and the development of vascular hypersensitivity. The nature of the process is such that the organisms are not killed off quickly, yet they do not destroy the valves. Positive latex fixation and other globulin disorders can be correlated with duration of disease in SBE; they are found in about 50% of patients. This does not occur in ABE.

ABE is a more vicious disease. Organisms attack normal valves (as well as damaged valves). Organisms are more voracious and destructive: beta hemolytic streptococci and Staphylococcus aureus predominate; gonococci and pneumococci are rarer. And these microorganisms usually destroy the valve and kill the patient—or are themselves killed—before antibody formation can occur. The phenomena of hypersensitivity that characterize SBE are not factors in ABE; the immune process never has a chance to get off the ground. And on this pathophysiologic difference we can sketch in the clinical manifestations of each.

Both disorders are characterized by constitu-

tional symptoms—fever and chills—due to infection. In ABE, the valve lesions are marked by destruction with ulceration and often perforation —ruptured sinuses of Valsalva, torn chordae tendineae, and ruptured papillary muscles; all are manifestations of an acute destructive process.

In SBE the pathology is quite different: an infected thrombus grows on a cusp—the forces of slow destruction are matched against those of repair. One can find fibroblasts and neovascularization of the fibrin clot, but the slowly destructive process has the upper hand; healing never quite catches up. One never sees, however, the ulceration or tearing of valves that occurs in ABE.

Abscesses of the adjacent myocardium are just not seen in SBE, yet in ABE septal ulceration is not a rare occurrence. Yet Meshel *et al*[5] recently reported an unusual patient who died with Streptococcus viridans endocarditis involving the right and non-coronary cusps of the aortic valve and the septum, with complete heart block, ventricular tachycardia and, finally, arrest. An old clinical aphorism has to do with the appearance of conduction disturbances in the febrile patient with a heart murmur: watch out for septal abscess and be prepared to intervene surgically. Such voracious behavior is not seen in SBE; in fact, there are documented instances of SBE that healed without antibiotics, in those terrible days before we had them.

A more controversial area is concerned with the myth of so-called "changing murmurs." Weinstein and others have said that in SBE murmurs do *not* change; in ABE the appearance of a murmur means perforation or tearing of a leaflet, and this is prelude to congestive heart failure in a matter of hours or days. And you had better alert the surgeons.

In suspected SBE, if the murmur changes the patient should be investigated for acute rheumatic fever, a much more common cause, often quite difficult to sort out early in the course. We are all familiar with the mitral and aortic diastolic murmurs of rheumatic myocarditis, which disappear when the inflammation cools down and the dilated valvar rings retract.

Then there is the phenomenon of embolization. This is seen in both ABE and SBE, but again there are cardinal differences. In ABE the emboli are softer, larger, and more friable, and they seem to go everywhere (brain, central retinal artery, kidneys). Usually they are heavily contaminated with viable bacteria and cause local abscess formation—"metastatic" infections.

The emboli that occur in SBE are also contaminated, but they produce bland infarcts because of the lesser virulence of the organisms involved and the existence of antibodies. Usually the Strep viridans does not have enough bite, and it is killed off by the local defenses. We see "showers" of emboli to brain, but no meningitis—to kidney, but no abscesses. In fact the term "focal embolic glomerulonephritis" expresses it quite well. The probability that this represents a vasculitis rather than an embolic phenomenon is quite high. In fact, the petechiae, Roth's spots, Osler's nodes, subungual splinter hemorrhages, and Janeway's spots probably are *not* embolic phenomena at all, but represent vasculitis. This was speculated upon by Emmanual Libman, 50 years ago.

Thus we have the situation of ABE with metastatic abscess formation from infected emboli, and SBE where the infected emboli cause bland infarcts. The mycotic aneurysms of SBE may seem to be an exception, but these are actually ischemic infarcts due to plugging of the vasa vasorum. There is no abscess.

Not so the mycotic aneurysm of ABE. Here the embolus carries Staphylococcus aureus, and when it plugs the vasa vasorum the lesion progresses to become an infected aneurysm which may well perforate.

This is a major difference between ABE and SBE.

Earlier I alluded to the hypersensitivity phenomenon in SBE. I said that it is not a factor in ABE, since if the patient is *not* treated properly he will die; if he *is* treated adequately the bacteria will be killed before they can provoke antibody formation.

In SBE the cutaneous and retinal manifestations are considered expressions of a vasculitis secondary to antigen-antibody reaction. The renal lesion, "focal embolic glomerulonephritis" is also a vasculitis. In such kidneys one can find evidence of chronic glomerulonephritis and/or epithelial crescents, or acute diffuse glomerulonephritis which is indistinguishable under the light microscope from classical poststreptococcal glomerulonephritis. And I suspect it will look the same under the electron microscope.

Another hypersensitivity manifestation of SBE is myocarditis. The Bracht-Wachter body is a small focal infiltration of round cells. Serial elec-

trocardiograms will show the ST elevations and symmetrical T-wave inversions of myocarditis. Earlier I discussed the myocardial ravages of ABE with septal abscess formation.

Finally, there may be arthritis in SBE. Arthralgias are more common, but objective arthritis can be seen *without* evidence of joint infection. The synovial effusion is sterile, sugar is normal, mucin is abnormal; organisms are simply not in the picture.

EPIDEMIOLOGY

Now let us turn from clinical manifestations to some epidemiological differences. From 1913 to 1948, 10 to 25% of SBE patients were over 50, and 2 to 10% were over 60. In a study done in 1948 to 1966, between 50 and 60% were over 50, and 20 to 30% over 60.[1] Obviously, more people are living longer with congenital or acquired heart lesions. They survive to get SBE on their damaged valves.

Although SBE occurred rarely in patients with coronary artery disease 20 years ago, today it is a relatively common finding. Needless to say, SBE still occurs most frequently on valves damaged by congenital or rheumatic heart disease. But its presence in patients with coronary and hypertensive heart disease is more common today, and both varieties of endocarditis have been reported in patients with myocardial infarction. These people are surviving their infarctions only to get endocarditis later. In addition, there is a whole new group of candidates: those whose lives have been prolonged by the cardiac surgeons' slick prosthetic patches and valves, on which bizarre organisms love to aggregate and grow.

Several other old aphorisms must be abandoned. That SBE "never occurs in luetic valvar disease" is no longer true. It happens rarely—luetic heart disease itself is now rare—but the complication of SBE has been reported. The teaching that SBE is "rare in congestive heart failure" (CHF) must also be tempered, now that many people are surviving repeated episodes of failure, or exist with mild chronic CHF much of the time.

However, the adage that mitral stenosis, especially with atrial fibrillation, offers an inhospitable soil for SBE apparently remains true. Bacteria prefer the hydrodynamics of regurgitation: they like to settle in eddy currents on the lee side of a sudden drop in pressure (as in regurgitant jets). At these sites, a fibrin clot will form with organisms lodging there and multiplying; antibodies arrive a little later to fix the organisms in and on the clot. This is not the environment of atrial fibrillation, where pressures tend to be equalized.

The bacteria themselves are changing. Streptococcus viridans is still the most common organism in SBE. But, in recent years, microaerophilic and anaerobic streptococci have been responsible for about 15% of SBE cases, and enterococci account for 5 to 10%. And these are difficult bacteria to eradicate.

As though these changes were not enough to test our clinical versatility, many new organisms are being identified in bacterial endocarditis. They include Staphylococcus albus and Mimae (a common respiratory and genitourinary tract inhabitant). Weinstein has stressed that the coagulase-negative Staphylococcus albus (now classified as Staphylococcus epidermidis) must not be dismissed casually as a culture contaminant. It has been known to cause chronic SBE of two to three years' duration, with ultimately high death rates attributable to delay in diagnosis. Finland[6] has said that the recent emergence of Staphylococcus aureus, Gram-negative bacilli (but not Shigella and Salmonella), Enterococcus, and Staphylococcus epidermidis is related to extensive use of antibiotics and appears to be nosocomial.

It is not fashionable to discuss bacteria without mentioning the mysterious protoplasts. It has been shown that blood cultures from SBE patients harboring protoplasts will be negative unless hyperosmotic media are used.

Burch and his group[7] reported Coxsacki B endocarditis in humans. And, in London, Kristinsson and Bentall[8] described six patients with Q-fever endocarditis due to Rickettsia burneti. This microorganism defies the usual media; 81% of their patients, though they had aortic valve murmurs, low-grade fever, anemia, elevated sedimentation rate, and elevated gamma globulin levels, had sterile blood cultures and a poor response to penicillin. All but one died in heart failure. The best drug was tetracycline, two grams a day for 30 days followed by one gram a day for six to 12 months. So we are obliged to beware of protoplasts, Coxsackie B, and Rickettsia burneti in our pursuit of infectious endocarditis vectors.

Fungi, particularly Candida, can lodge on normal heart valves, and they seem to have a particular affinity for the bare metal struts of prosthetic valves. As a matter of fact, when a

patient with bacterial endocarditis flips an embolus large enough to occlude a major vessel, suspect Candida. Large mycelium-fibrin balls—can lodge in large vessels—like the friable fragments from a tattered left atrial myxoma. Cheng and Yu reported a patient who developed Candida parapsilosis infection on a prosthetic mitral valve.[9]

A case of Spirillum minus endocarditis has been described. And a patient with Serratia marcescens endocarditis involving the tricuspid valve—resistant to antibiotics—was cured by aggressive surgical debridement.[10]

Thus, isolated case reports can be cited identifying a host of strange microorganisms that infect heart valves. Perhaps the ecology of microbiologic flora is changing in response to antibiotic scattergun techniques or as a result of natural selection.

Back in the late 1940's, my old chief, Sol Katz, and Hugh Hussey reported some cases of acute tricuspid endocarditis in heroin addicts.[11] I think it was the first paper of its kind; certainly it was a novel series for the time. But now, right-sided endocarditis is a disease that must be in every clinician's lexicon. The modern junkie comes in numerous guises and "shoots" anything that can be rammed through a needle into a vein.

Therefore, we must be alert for vexing, complex clinical problems. Not only may we be confronted with an infection—a suppurative thrombophlebitis or infected tricuspid valve or a patch of staphylococcal pneumonitis—but also we must anticipate an endless variety of non-infectious particulate junk that is being insinuated into veins and may come to lodge in lungs. For example, talc is a common bulk product in antihistamine tablets; when these are crushed and mixed with water and then pumped into a convenient vein, just visualize the complicated clinical problems that can be created: endocarditis, or lung abscess, or "blue velvet" syndrome (an alveolar-capillary block with cyanosis), or any combination of these!

Of course, right-sided endocarditis is not limited to drug abusers—it can be found in patients with bladder infections, prosthetic patches, intracavitary pacemakers, or artificial valves on the right side; but such cases are almost medical curiosities. Thus, the clinical combination of sudden pneumonia (especially if it is recurrent), plus murmur and fever, should set our computers in motion. If the patient survives the infection, the cause of death is usually right-sided failure complicated by renal or hepatic insufficiency.

To make matters even more complex, about one-third of these patients will have no murmurs. Blood cultures at the onset are usually negative, since the lung is an effective biological filter. The exception is tough old Staph aureus—once his infected embolus lodges, it becomes an abscess and spews organisms into the greater circulation, where they can be cultured.

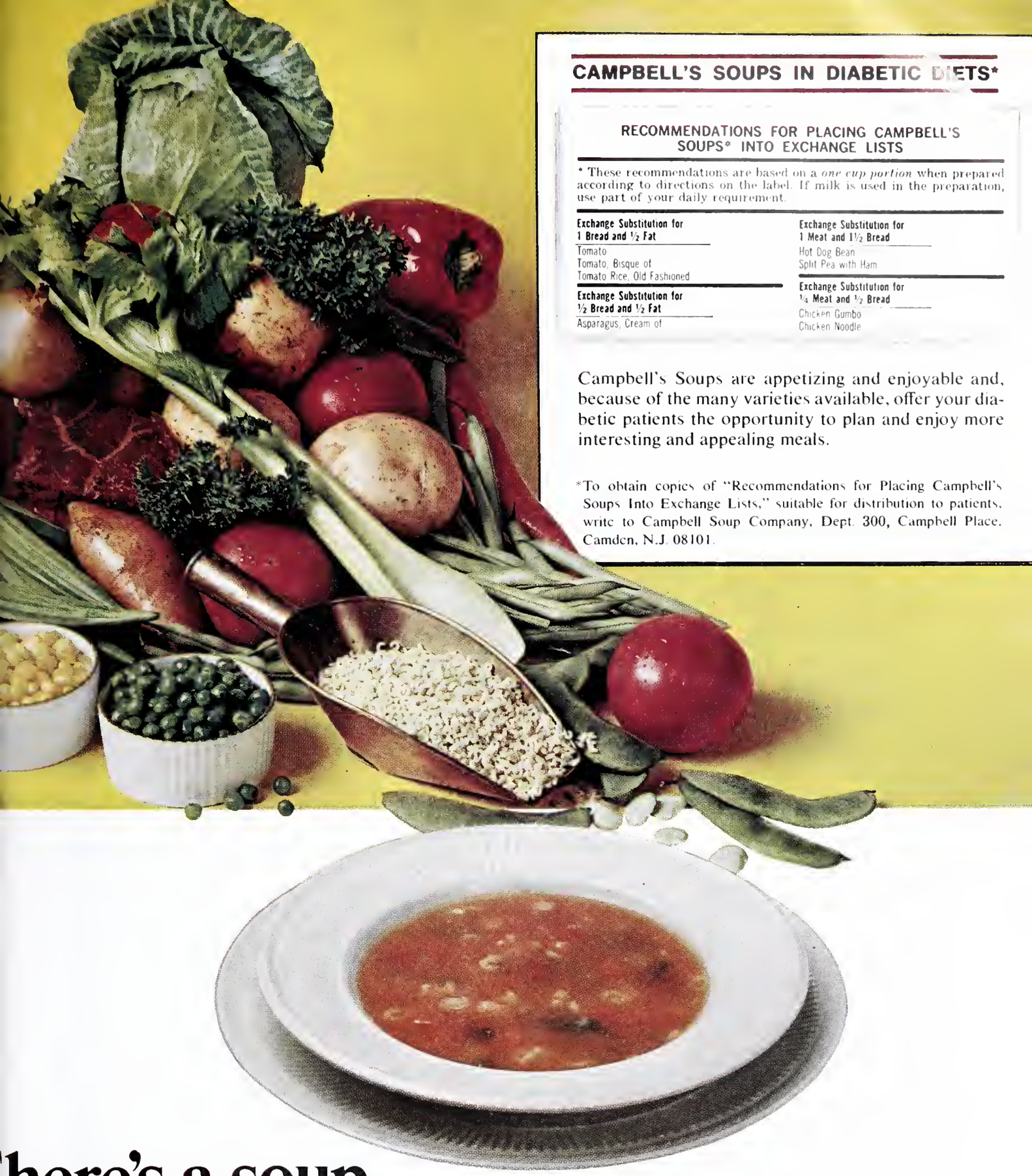
In the pre-antibiotic era, 64% of patients with endocarditis died of infection; now only 21% do. Congestive heart failure used to be the cause of death in 12%, now it is the cause in 61%. The incidence of major embolism was 14% before antibiotics; now 8% die of this complication. Other causes still contribute approximately 10 to 15% of deaths. A final disquieting note can be found in the recent report by Levison, et al.[12] They found 17 of 268 patients with endocarditis who had more than one episode. Fourteen had two bouts with endocarditis, and three had three. The patients were younger than the average and had more Strep viridans infections, and five had congenital heart disease. Ultimate cures were achieved in 89%.

Thus the key factors in prognosis are age, congestive heart failure, aortic valve involvement, unusual microorganism, and the underlying heart disease. The therapy of endocarditis is a subject unto itself and is a source of a mild controversy, but potent cidal agents are available. This is the subject of an excellent review by Williams, et al.[4]

Thus we have a relatively rare, but potentially curable disease—if we recognize it early and pounce on it quickly.

REFERENCES

1. Weinstein L: Lecture during professor-pro-tem visit to Walter Reed General Hospital, Washington, D.C., June, 1969.
2. Jones HR Jr, Siekert RG, Geraci JE: Neurologic manifestations of bacterial endocarditis, *Ann Internal Med* 71:21-28, 1969.
3. Case Records of the Massachusetts General Hospital, Case 2-1970, *New England J Med* 282:89-97, 1970.
4. Williams TW Jr, Viroslav J, Knight V: Management of bacterial endocarditis, 1970. *Amer J Med* 26:186-191, 1970.
5. Meshel JC, Wachtel HL, Graham J: Bacterial endocarditis presenting as heart block, *Amer J Med* 48:254-255, 1970.
6. Finland M, Barnes MW: Changing etiology of bacterial endocarditis in the antibiotic era, *Ann Int Med* 72:341-348, 1970.
7. Burch GE, Colcolough HL Jr: Progressive Coxsacki viral pancarditis and nephritis, *Ann Int Med* 71:963-970, 1969.
8. Kristensson A, Bentall H: Medical and surgical treatment of Q fever endocarditis, *Lancet* 2:693-696, 1967.
9. Cheng S, Yu L: Candida parapsilosis endocarditis following heart surgery, case report, *Hawaii Med J* 29:637-641, 1970.
10. Alexander R, Holloway GA Jr, Honsinger RW Jr: Surgical debridement for resistant bacterial endocarditis, *JAMA* 210:1757-1759, 1969.
11. Hussey H, Katz S: Infections resulting from narcotic addiction: report of 102 cases, *Amer J Med* 9:186-192, 1950.
12. Levison MF, Kage D, Mandell GL et al: Characteristics of patients with multiple episodes of bacterial endocarditis, *JAMA* 211:1355-1357, 1970.



CAMPBELL'S SOUPS IN DIABETIC DIETS*

RECOMMENDATIONS FOR PLACING CAMPBELL'S SOUPS* INTO EXCHANGE LISTS

* These recommendations are based on a *one cup portion* when prepared according to directions on the label. If milk is used in the preparation, use part of your daily requirement.

Exchange Substitution for 1 Bread and ½ Fat	Exchange Substitution for 1 Meat and 1½ Bread
Tomato	Hot Dog Bean
Tomato, Bisque of	Split Pea with Ham
Tomato Rice, Old Fashioned	
Exchange Substitution for ½ Bread and ½ Fat	**Exchange Substitution for ¼ Meat and ½ Bread**
Asparagus, Cream of	Chicken Gumbo
	Chicken Noodle

Campbell's Soups are appetizing and enjoyable and, because of the many varieties available, offer your diabetic patients the opportunity to plan and enjoy more interesting and appealing meals.

*To obtain copies of "Recommendations for Placing Campbell's Soups Into Exchange Lists," suitable for distribution to patients, write to Campbell Soup Company, Dept. 300, Campbell Place, Camden, N.J. 08101.

'here's a soup for almost every patient and diet .for every meal and, it's made by *Campbell*

Special Report

Life's Window — The Pupil

We doctors and nurses need to be aware of patients' feelings and attitudes. The following subjective account of a code 500 situation by a highly intelligent "victim" should make us all stop and think. In CPR, the state of dilation and the responsiveness of the patient's pupil is a window for us through which we look for life. The life we seek is apparently capable of looking back at us—an extracorporeal spirit perhaps!

J. I. Frederick Reppun, M.D.

Months ago I underwent open-heart surgery for replacing the mitral valve. The morning after surgery I had two periods of fibrillation. Due to this difficulty, I spent eight days in intensive care. It has been suggested by a Honolulu doctor that perhaps other doctors would be interested in what takes place in a patient's thinking when he or she is presumed to be unconscious or semi-conscious. This narrative is subjective, and not clinical.

TIME, as measured by clocks or calendars had very little meaning. It stretched, condensed or disappeared as I floated in and out. Place was also a problem. I often became disoriented in my mind as to where I was, and why. I would dream that I was in another time, in a Wild West setting, or in an old California ranch house. These homes were institutional, complete with the nurses that were really around me. The persons with the machine for inhalation therapy were also included in the fantasies (but not the doctors). So, in this narrative, the sequence is as correct as I can remember it, as correct as I could remember it at the time, but I have no idea of the length of time between episodes.

First of all I remember seeing my husband, doctors, and nurses one of whom told me about the things I was hooked up to: IV's, Foley, and the oscilloscope which was monitoring the heart beat and, as I remember it, blood pressure. This latter remembrance may not be fact. This information was given at my request.

Next, I became aware at some later time that my heart was not beating as it had been, that it was sort of fluttering. The alarm was sounding, people gathering. I looked at the oscilloscope and saw a completely different wave. Although I have no knowledge of exactly how the heart beat should look, I have been around these instruments enough to know that what was showing was peculiar. A nurse opened my eyelid several times, shining a flashlight directly in the eye. I thought that I would like to tell her, "I am still in there," but I could not speak with a tube in my nose. I did not have enough energy, either. At this time I thought very strongly, "I can't go now. I have to be here to see — (my husband) when he comes. STOP IT!"

Unconsciousness.

Another time the same thing happened. I didn't think much this time, except for wanting to tell

the nurse that I was "still in there" when she shined the light in my eye.

As a sequel to this, I asked for the pad of paper when my husband appeared, and wrote on it 'die?' He said "No." One of the surgeons was present, and said in a rather angry tone, "You are not going to die." I was irked because he did not understand. Later I found that there was some sort of weird time lapse. I thought that the fibrillation episodes had just taken place, but actually a day or so had gone by, with many periods of consciousness in between.

It did not take long to discover that the nurses did not know whether I was awake or not, unless I opened my eyes. This I tried to do whenever they would say anything about me, as I did not want them to say anything I wasn't supposed to hear. But opening the eyes was sometimes a great effort.

One time after the tube was out of my nose, one nurse said, 'She's sighing!" I was sure that this was something bad, as several relatives hyperventilate when they shouldn't. A little later, a nurse said. "She's sighing; that's good." This made me feel better about it, though I really didn't know just what it was that I was doing.

Sometime soon after the tube was removed from the nose, I gave one of the nurses a very bad time. I was perfectly convinced that what I was feeling was true, and though I never found out the reaction of the nurses who rallied around, I'm sure that they thought I was out of my mind. To me, my mind was clear. I told the nurse that I wanted to be allowed to get up and go home. In my mind I could not understand why I was in essence being kept a kind of prisoner. That I was in a hospital I knew. I didn't know why. When the nurse said, "Mrs. —, don't you know what has happened?", I said "Nothing has happened and I want to go home." I had no feeling of anything being out of the ordinary as far as I was concerned.

This argument went on for quite a while, neither one convincing the other. It finally ended when I told her she was beautiful, which she was. The nurses were switched on me. When I asked why, the new one said that it was thought best, because Mrs. So-and-so seemed to have a bad effect on me. I wish I could apologize to her. But I still remember the strong feeling I had that there was nothing wrong, and I should be allowed to leave.

After leaving the Intensive Care Unit on the eighth day after surgery, I had a day or so of seeing things on the wall that were not there. I knew that they were not there, but they wouldn't go away. Seaweed dripping down the wall. Large multi-masted sailing vessels with lights in their rigging moving through garlands of flowers. I was glad when these phenomena disappeared, and I was left to recover in peace.

Editorial

Harry L. Arnold, Sr., M.D.

1887-1971

In the death of Harry L. Arnold, Sr. on July 25, 1971, Hawaii lost one of its most distinguished citizens, and the medical profession one of its members with many illustrious accomplishments.

Born in Owosso, Michigan August 13, 1887, he decided to follow in the footsteps of his father, graduating in medicine from the University of Michigan in 1911. Being a brilliant student, he acquired all the academic honors that were accorded such individuals at that time.

After a few years in private practice, Dr. Arnold received a commission in the United States Army shortly before the beginning of World War I. He graduated from the Army Medical School in Washington, D.C. in 1916 and was planning to make the regular Army his career. No doubt this would have been the case had he not been sent to Hawaii, where he came under the influence of Dr. George F. Straub. Dr. Straub, at the time, was seeking an internist in preparation for establishing a group practice, later to be known as the Straub Clinic. Dr. Arnold, then a Major, resigned his commission and joined the organization in April 1921, and continued to practice internal medicine until his retirement in 1967. During this time, Dr. Arnold received practically all the honors that can be bestowed upon a member of the medical profession living in Hawaii.

In 1928, he was elected President of the Honolulu County Medical Society and in 1938, President of the Territorial Medical Association. When not President of these organizations he for many years took part in practically all of their activities, either as chairman or as a member of various committees. His sage advice was particularly effective as a member of the Legislative Committee and as a member of the Council.

Dr. Arnold became a founding Fellow of the American College of Physicians in 1929. A local chapter was formed in 1937 and he was elected to its National Board of Governors for the next ten years.

He became a Diplomate of the American Board of Internal Medicine on its inception in 1934.

Dr. Arnold contributed much to the development and present excellence of Queen's Hospital, now known as Queen's Medical Center. He became its Chief of Medicine in 1934 and Chief of Staff in 1939, serving in these capacities until he resigned in 1957.

He played a role of major importance in preparing our local medical facilities for the day of the blitz at Pearl Harbor in 1941, being Chairman, at the time, of the Medical Preparedness Committee of the County Medical Society. He served the ensuing year as head of the Medical Section of the Territorial Office of Civil Defense. His previous military training made him particularly effective in these capacities and much of the efficiency in taking care of many problems in medical care during these trying times resulted from his efforts.

Dr. Arnold was much interested in the care of patients with tuberculosis, which resulted in his being elected to the Board of Trustees of Leahi Hospital in 1931, and to the Presidency of this Board in 1947, in which capacity he served for the ensuing twenty years. He made many contributions to eurrent medical literature and he was an authority on poisonous plants of Hawaii. He published a book, in 1944, concerning this subject, to which many physicians still refer, especially when confronted by individuals possibly poisoned from such a source.

HAWAII MEDICAL JOURNAL

In 1932, Dr. Straub, following extensive study in Europe and on the mainland, published one of the early books on the then developing field of thoracic surgery. Dr. Arnold contributed four chapters dealing with the physiology of respiration and other medical aspects of chest diseases.

Dr. Arnold engaged in many other activities for the betterment of the welfare of the citizens of Hawaii, but space precludes their enumeration.

For many years he was interested in and contributed to the development of orchids in Hawaii. Another of his hobbies was wood turning and he made many beautiful objects of wood such as bowls, trays, cribbage boards, bracelets and the like, all for the enjoyment of his many friends.

I well remember my first two contacts with Dr. Arnold, both in the interest of his friends who had been hospitalized. The first occurred at the base hospital of Camp Zachary Taylor, Kentucky, where I was stationed during the first World War and where Dr. Arnold was Camp Surgeon. The next, in my office in Honolulu before I joined the Straub Clinic. I had just removed the kidney from the wife of one of his subordinates. Both times I was impressed by his gentlemanly military bearing and by his direct and intelligent approach to the problems involved.

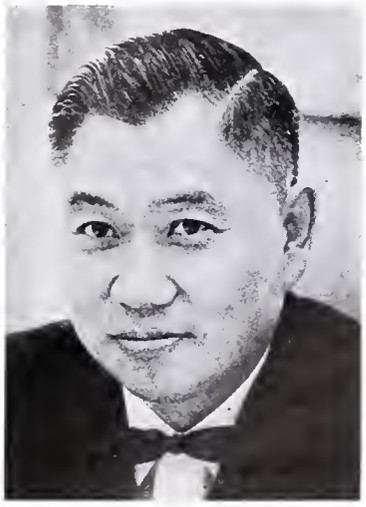
My subsequent contacts began in 1922 when I became associated with him in the practice of medicine, which continued as a most happy and stimulating experience for forty-five years. I've often said that I never knew anyone for whom I had greater respect and admiration than I had for Harry Arnold. Over our many years of intimate association, I never knew him to deviate one iota from what he thought to be honest, honorable, and fair, whether dealing with a patient or with some individual of influence and affluence who wished to color a situation to his advantage. His intelligence was razor sharp and he had the ability to cut through frills and get down to the meat of the problem with unerring accuracy, which on occasion gave some the feeling that he was indifferent to their opinions, especially when they were bolstering their arguments with irrelevant detail.

During my long surgical career, it was always a source of great satisfaction to have an internist like Harry Arnold at my side, to whom I could turn for assistance with full confidence that no one could be found more capable, more sincere, or more interested in the welfare of the patient.

To me, Harry Arnold represented the type of man which we in our profession should strive to emulate. First, he was well educated and he kept himself well informed of current medical developments. He was a gentleman under all circumstances, and he had the appearance that a man of the healing art should maintain, which is so lacking in so many present-day graduates in medicine. He was not a seeker of publicity, but in his quiet way he did more for the community in which he lived in than many in the daily spotlight. He had a happy home life and he and his wife, Meda, reared a daughter and son who likewise are a credit to Hawaii.

When I attempt to evaluate the long and fruitful life of Harry Arnold, I fail to see where he could have accomplished more for the betterment of humanity. In this day and age, when so many seem to have lost all contact with reality and exhibit so few of those qualities that have made America great, one cannot help but realize what a pity it is that so few individuals with the sterling qualities of Harry L. Arnold are still among us.

JOSEPH E. STRODE, M.D.



The President's Page

To share with you the latest developments on the many projects HMA is involved in, this issue's "President's Page" has changed its format somewhat, but in no way wishes to compete with Henry Yokoyama's *infamous* "Notes and News" section.

EMCRO

- A check from the National Center for Health Services Research and Development (HSHA) in the amount of $25,000 has been received. This represents the initial payment on the $180,000 1st year grant, funding the Experimental Medical Care Review Organization (EMCRO) project.
- Chairmen to head the various EMCRO related committees have been appointed by your Executive Committee. The Chairmen are now in the process of staffing their committees and as soon as this is accomplished, a complete report will be made to you identifying the committees, chairmen, members and functions.
- The project coordinator is in the process of effecting another series of seminars. These, to review and discuss the ambulatory phase of the project.

LEGISLATION

- The HMA suit against the State Department of Labor concerning the revisions made to the Workmen's Compensation Law is before the courts. Nothing new seems to have happened there, so nothing new to report.
- A new legislative session will soon be upon us. If you have any new legislation you would like to see considered, or if there is any current legislation you feel should be reviewed and revised, please contact our Legislative Committee, chaired by Dr. George Goto.
- New legislation in the areas of drug abuse and professional liability is under consideration.

DRUG ABUSE

- The week of October 3, 1971 was proclaimed by President Nixon to be DRUG ABUSE PREVENTION WEEK. To capitalize on the large amount of publicity this would be given by the major media, Governor Burns assisted in *localizing* the publicity campaign by declaring the same week as HAWAII DRUG ABUSE PREVENTION WEEK.
- We owe the Governor our sincerest mahalo for his support of our efforts and particularly for his opening remarks on the specially scheduled "Medically Speaking" program. In case you missed the program, it devoted itself to an in depth discussion on "Amphetamines—Medical Value and Abuse Potential."
- Our position on the use of amphetamines has generally received favorable comment.

Robert Y. H. Chinn

Slants and Angles

HAWAII MEDICAL JOURNAL

Fountain of Youth

Recently, a pleasant, middle-aged lady just back from an extended vacation in the Orient came into the office for a checkup. She looked at least 10 years younger than the last time I had seen her, a few months previously. "That vacation certainly did you a lot of good," I remarked. Smiling, she reached into her handbag and produced a large box of red capsules—KH3, the miracle rejuvenator.

The story of KH3 began in the early 1950's at the Bucharest Geriatric Institute where Dr. Ana Aslan started giving regular injections of an acid buffered procaine solution, which she called "Gerovital," to some of the aged and infirm patients. She reported marked and in some cases miraculous improvement in their physical and mental status, regression of many degenerative processes, and prolongation of normal life expectancy.

Man has eternally sought same way of retarding or reversing the natural processes of ageing (as you recall, that's what Ponce de Leon was looking for down in Florida) and as always, the pharmaceutical industry has been equal to the challenge. An oral form of this new wonder drug has been produced in Germany, thus obviating the necessity for painful injections and expensive weekly trips to the doctor. This was done by combining the procaine with hematoporphyrin, which is said to act as a catalyst and synergist. The combination, called KH3, is then enclosed in a gelatin capsule which is taken daily, and more or less indefinitely, to insure maximum benefit.

Following this pharmaceutical triumph, sales boomed, the capsules being readily available without prescription in many foreign countries, including Hong Kong and the West Indies, where they can be purchased by American tourists. Needless to say, the preparation cannot be legally obtained in the United States, as importation is prohibited by the FDA.

The crucial question, of course, is: does this treatment really work or is it just another exotic placebo? Personally, I do not know the answer; while other members of the medical profession seem to be divided into a small group of enthusiasts and a larger skeptical faction who believe it's all a lot of baloney. Admittedly, the few clinical trials conducted in this country have been disappointing, but Dr. Aslan says this was because the correct formula for buffering the procaine was not used. Perhaps some more carefully controlled studies are indicated before a firm and authoritative decision can be made.

Remember when William Withering said in 1785 that drinking an extract of foxglove was good for the Dropsy? That must have sounded pretty far out too!

Vanishing Orchid

Those enigmatic Russians once again appeared to be resurrecting the story of Adolph Hitler and his absent testicle.

In 1945 following his partial immolation in the ruins of the Chancellery Garden, Russian doctors carefully examined his remains and found to their surprise that the left testicle was missing. Psychologists immediately seized on this story ascribing many, if not all, of Der Fuhrer's idiosyncracies, which ranged from misogynism to megalomania, to be a direct consequence of deep-seated insecurities resulting from his very personal loss.

This column now wishes to refute these wild claims, having heard from an unimpeachable source that the gonad is indeed not missing at all, but when last heard from was alive, well, and residing in Argentina.

W. P. Jones, M.D.

Inside HMA

HAWAII MEDICAL JOURNAL

Telling It Like It Is

. . . When did you last write your congressman? It must have been some time ago. Don't you think it's important for your congressman to share the benefit of your views on national legislation and the activities of the government in Washington? My good friend, Congressman Spark Matsunaga, had a special meeting with the **National Legislation Committee** on July 9, 1971. He stated that he received very little communication from physicians in Hawaii in regard to national issues. He twice stated that he would appreciate being kept informed of the stand of HMA on various issues. I think we should have four physicians assigned, one to each of our four congressmen, to act as official liaison officers between HMA and our two Senators and two Representatives. But even more important, every member of the association should periodically write his congressman, telling him about your views. If the issue is important, then telephone or telegraph. It does no good to argue with each other about what is going on in Washington. It does a great deal of good to speak literately to one's congressman. Sparky stated that he felt no action would be taken this year on national health insurance, but that the bill eventually would pass with one chosen by the unions. Perhaps if enough physicians write from all over the country, that can be changed.

. . . About the same time I wrote my last column, on the subject of "Goals" for HMA, the **Bureau of Research and Planning** was discussing exactly the same thing. Dr. Gordon stated: "We need to outline the goals of our profession as against the needs and self-interests of our association members." Fred Reppun outlined what I consider a very reasonable set of proposed goals. From the spaces a good overall set of goals could probably be developed if this is pursued to a finish. Keep at it, Fred!

. . . **Health Manpower** is still struggling with the question of physicians' assistants. The February 11, 1971 issue of **New England Journal of Medicine** has an excellent editorial on the need for the proper legislation for these people because the physicians' assistants will be trained to assist a specific type of physician with some danger of setting up a whole raft of licensure laws to license each type, ie, pediatric assistant, orthopedic assistant, etc. Let's work to avoid this, to keep a simple overall approach, and to keep control of the whole matter solidly in the hands of physicians. **Cancer Committee** is studying the question of oncology units. If such are established here, most of us would prefer to see a unit in each hospital, but all the hospitals appear to be resisting such a move. If that continues, it is quite likely that federal planners, through the use of federal funds, will establish a separate cancer center.

. . . **Scientific Program** has chosen for the theme of next year's HMA meeting: "Pathology As It Relates to Clinical Practice," and are beginning to line up speakers.

. . . **Environmental Help Committee** has lost its chairman, the outspoken James Erickson, who has gone to take a residency to specialize full-time in this field. The committee feels, and I agree, that HMA should be more solidly involved in activities going on in the State in this field. Among other proposals are ones for a bi-weekly newspaper column on this field to be written by HMA members. I certainly think physicians of Hawaii should be helping to guide activities and discussions in this field, not only because we're better prepared to discuss such problems, but because perhaps we can help avoid the excesses of emotion which are being injected into the various appeals and activities and which are already beginning to stimulate a "backlash" against pollution-mania.

. . . **TV-Radio** reeived a report that TV programs are being cut back from 4 to 3 programs a month because of budgetary problems. Beginning in January the program will be in color. A TV station states that the chiropractors are beginning to agitate for a program of their own, similar to ours, to present their own story to the public. Let's spike that, somehow.

. . . Also hard at work and doing a good job are **Filipino Speakers and Japanese Speakers Bureaus.**

Aloha.

JOHN BROWN, M.D.

Hawaii Academy of General Practice

. . . Health Womanpower

If you only knew what goes on in our town, you would be amazed at the number of agencies, committees and sub-committees concerned with projects and schemes focused on the newer aspects of developing paramedical personnel—particularly the physician's assistant. Even the tape-and-steel brained computer is a candidate for the post!

The reason for all this furor is obvious: There are too few physicians to satisfy the increasing demands of an exploding population. It is well known that the rate at which new physicians are entering the ranks is not rapid enough, and medical schools are too expensive to enlarge or initiate. Also, the restrictions of a legal or of a professional type on development, training, certification and licensure, of placement and of privileges granted to qualified persons are not being eased fast enough, they say.

Nevertheless, the push for such development is there, both on a national and a local level. We should acknowledge gracefully the source of such impetus—largely from the so-called consumers. This, however, does not absolve the medical profession from assuming the responsibility of guiding its course; we have the know-how, and we should put it to use.

One of these concepts that is much in the public eye is the utilization of ex-military corpsmen as medical assistants. The implication here is that these men, already experienced and with their hands actually bloodied in the care of acute trauma, can be additionally, briefly and rapidly trained to become "extensions" of the practicing doctor—working alone even, except that the "assistant" will be at the end of a leash: The telephone.

Our City & County physician has already initiated a program for his Emergency Medical Technicians (EMT), and he has already received a grant for an in-service program to train his ambulance crews to this end. Such upgrading programs are commendable and should produce desired results in extension of high quality public service to the community.

The University of Hawaii School of Medicine is already deeply involved in planning for training programs for paramedical personnel, perhaps modeled after existing programs on the Mainland. Young men of the proper caliber may look forward to three or four year college-type programs aimed at the granting of degrees with in-service training included or additionally for a higher certification, that will qualify them to be "half-doctors."

This is all well and good from a long-term point of view. Such partially trained semi-professionals can undoubtedly be fitted into slots and fill future needs in health care. However, we need to look no further away than our hospitals and offices to realize that we have already available to us a manpower pool that has not been tapped.

This "womanpower" pool is made up of the college-graduated and registered nurses. Just because the most of them are women, is no reason to ignore them in favor of corpsmen who are more experienced than educated!

Witness the late rise to prominence within their profession of the ICU and CCU nurses. With a relatively short but intensive course of additional training, the best of these RN's have acquired skills and responsibilities of which we physicians can be very proud. Why not take from the same pool from which these ICU nurses came, others who are well-educated and experienced in nursing care, send them to appropriate training centers such as medical schools or hospitals and let them become the first of the true physician's assistants? Many an old-time country doctor trusts his nurse already to diagnose and to treat in his absence. Many an outlying dispensary nurse has sutured a wound; corpsmen do not have that experience exclusively. Many a modern nurse is skilled in venoclysis, in monitoring medical parameters, in C-P-R, etc.

To place undue emphasis on developing "man" power when we already have available and capable "woman" power, would be not only a mis-direction of purposes, but would be a slap in the face of a profession to which we have accorded too little honor (we take them too much for granted, I guess!). Indeed, if lesser trained men are suddenly catapulted to more responsible and better paying positions as almost-doctors, we may well see an eruption of Women's Lib the likes of which has never been before!

J. I. Frederick Reppun, M.D.

X-ray View Box

HAWAII MEDICAL JOURNAL



• A 61-year-old Japanese lady had lost several pounds of weight during the past year and also developed nocturia, occasional abdominal cramping and noticed an increase in her abdominal girth. What is your diagnosis?

Exploratory laparotomy revealed a disseminated ovarian carcinoma with ascites. The preoperative film above as part of an intravenous pyelogram showed ascites, lower abdominal and pelvic mass and psammoma bodies which are indicative of metastatic carcinoma, usually ovarian.

Submitted by

D. R. GRININGER, M.D.
HAWAII RADIOLOGICAL SOCIETY

HAWAII MEDICAL JOURNAL

Book Reviews

WINFRED Y. LEE, M.D.

The Low Vision Patient; Clinical Experience With Adults and Children

By Eleanor E. Faye, M.D., F.A.C.S., 237 pp., $9.75 Grune & Stratton, 1970.

THE BOOK aims to help provide the most effective vision for partially sighted people, both children and adults.

The book gives a methodology of history taking, examination and treatment for different groups of individuals by the use of case histories. Sources for obtaining low-vision devices are provided.

Coordination of medical disciplines and modalities to secure best vision is stressed. Practical application of commonly known laws of optics is used throughout.

Ophthalmologists, eye residents and teachers of subnormal vision will find this book of benefit.

SAU KI WONG, M.D.

★Synopsis of Anatomy

By Liberato J. A. DiDio, 508 pp., 388 illus., $11.95, The C. V. Mosby Company, 1970.

THIS TEXT though entitled "Synopsis of Anatomy" is a rather extensive anatomical text in its own right.

The objective as stated in the preface, "a concise and yet comprehensive presentation of human anatomy," has been achieved.

The text benefits by the contributions of a number of distinguished and dedicated anatomists.

The text will be useful as an excellent guide and review source for physicians in all levels of medical science.

The contents are divided into twenty-two chapters that generally follow a systems orientation (i.e. digestive system, reproductive system) but there is also space devoted to cytology, embryology, and anthropometry.

The style, the up-to-date references, the inclusion of material on ultra-structure and function all convince this reviewer that anatomy is not a "dry branch on the tree of Biology," but is indeed living and growing and performing an integrative function.

I recommend this as a useful text for all interested in the human body, its structure, function, and malfunction.

CHAS. B. ODOM, M.D.

Also Received

Handbook of Obstetrics and Gynecology

By Ralph C. Benson, M.D. 4th ed. 774 pp., $6.50, Lange, 1971.

A CONCISE PAPERBACK digest which should be of great benefit for house staff members and clinicians desiring a resume and review.

Red Cell Metabolism; A Manual of Biochemical Methods

By Ernest Beutler, M.D. 146 pp., $7.50, Grune & Stratton, 1971.

THIS PAPERBACK manual succinctly summarizes much of the recent development in red cell metabolism. Although not completely comprehensive, it very adequately discusses the major enzymatic and intermediary metabolic disorders of clinical consequence.

Speech Pathology; An Applied Behavioral Science

By William H. Perkins, Ph.D. 449 pp., $11.75, Mosby, 1971.

AN EXCELLENT REFERENCE source for those with special interest in this field of behavioral science.

Medical Resident's Manual

By William J. Grace, M.D., F.A.C.P.; Richard J. Kennedy, M.D., F.A.C.P.; and Frank B. Flood, M.D., F.A.C.P. 3d edition. 439 pp., $6.75, Appleton-Century-Crofts, 1971.

A MANUAL of practical significance for most house staff officers prepared by the Medical Department of St. Vincent's Hospital and Medical Center of New York.

Ciba Symposium on Sensorineural Hearing Loss

358 pp., 1970.

Ciba Symposium on Alzheimer's Disease and Related Conditions

316 pp., 1970.

Ciba Symposium on Taste and Smell in Vertebrates

402 pp., 1970.

Ciba Symposium on Molecular Properties of Drug Receptors

298 pp., 1970.

THE USUAL excellent and comprehensive Ciba Symposiums that emphasize the basic pathophysiology of these selected subjects.

★ means highly recommended.

In Memoriam – Doctors of Hawaii

This is the ninety-second installment of In Memoriam—Doctors of Hawaii.

Walter Seong Chinn

Walter Seong Chinn was born March 30, 1899, in Honolulu, the son of Chinn Chun Shee and the late Chinn Hung. He was educated at St. Louis College in Honolulu, graduating in 1917, and then attended Creighton University in Omaha, Nebraska. His medical degree was granted by Rush Medical School in 1924. Dr. Chinn interned at Los Angeles County General Hospital.

Following internship, Dr. Chinn returned to Honolulu in April, 1924, and began a general practice which was to cover the next 21 years.



He married Miss Ethel Kam in Honolulu. Subsequently, they became the parents of two daughters, Marion Jane and Laura Ann.

In private life the doctor was an active Mason, being a member of the Hawaiian Lodge,No. 21, F. & A. M.; the Honolulu Scottish Rite bodies; the Honolulu Chapter, No. 1, R. A. M.; Honolulu Commandery, No. 1, Knights Templars; and Aloha Shrine. He was also a member of the Honolulu Medical Society and the Territorial Medical Association.

Dr. Chinn died on January 9, 1946, at the age of 46.

Haliburton McCoy

Haliburton McCoy was born at Asheville, North Carolina, in 1891.

He graduated from Trinity College, now Duke University, and received his medical degree from the University of Virginia in 1918.

At the beginning of World War I, Dr. McCoy entered the Navy, joining the medical corps. After the war, he served with the U. S. Marines in the West Indies for one year. Following which, he joined the U. S. Public Health Service in New York for a year. From the public health service he went into private practice in Crozet, Virginia.

In 1929 Dr. McCoy came to Maui to join the staff of the Puunene Hospital of the Hawaiian Commercial and Sugar Co., Ltd.

The doctor was married and the father of two sons, Haliburton, Jr. and Garnett, and a daughter, Virginia.

Dr. McCoy died July 1, 1939, at Puunene, Maui, at the age of 48.

He was a leader in medical and civic circles on Maui, serving as president of the Maui Medical Association, vice-president of the Territorial Medical Association, member of the American Medical Association, chairman of the Maui Mental Health Clinic, member of the Maui Boy Scout council and of the Maui Post No. 8 of the American Legion. He was also a member of the Crozet Masonic Lodge, a Royal Arch Mason and a Knight Templar.

HAWAII MEDICAL JOURNAL

Randolph Lucien McCalla

Randolph Lucien McCalla was born into a tradition, sometimes called heritage. He had known nothing from his earliest remembrances but medicine. His short-lived life was in the finest traditions of the profession for which he had been raised. Six generations before, his life had been laid out for him, and he was the seventh of a direct line of McCallas' to carry the mantle of Doctor of Medicine.

Dr. Randolph Lucien McCalla was born in Trinidad, Texas, on March 10, 1898. Shortly after his birth, his family moved to Boise, Idaho. His early, formative years were culminated by graduation from Boise High School in 1912.

Dr. McCalla went on to school at Georgetown University where he received his A.B. with honors, in 1916. From there he proceeded to Harvard University Medical School where he studied from 1916 to 1918. He completed his medical studies at Columbia University and received his M.D., again with honors, in 1920. He served his internship from 1920 to 1921 at St. Agnes Hospital in Baltimore, Maryland. He then returned to the family home in Boise, Idaho, where he set up practice from 1921 to 1924.

However, he was restless and longed to transplant to a new clime. The offer of a position as resident physician at the University of California Hospital presented an opportunity for change. He also served as house officer at the San Francisco Hospital from 1924 to 1925.

While at the University he served as Assistant in Medicine from July 1, 1924, to June 30, 1925; Instructor in Medicine from July 1, 1925, to June 30, 1929, engaging in special research in *materia medica;* and Assistant Clinical Professor of Medicine from July 1, 1929, to June 30, 1930. In 1927 he was also in charge of the staff at Laguna Honda Home, San Francisco.

On July 8, 1929, he married Mary Devitt of San Jose, California, at St. Thomas' church in Reno, Nevada.

Soon after, he again became restless and followed the call of the Islands. He was appointed physician in charge with the Dole Hawaiian Pineapple Company at Lanai City, Lanai. During his four years with the plantation two children were born: Kathleen Eileen (Mrs. Mel Berlinger) and Thomas Devitt. After his death his wife returned to Lanai where a third child, Randolph Lucien, Jr., was born on February 12, 1937.

His years on the Plantation Island were not uneventful. There was an Hawaiian village on the northern end of the Island whose only access was a winding, narrow trail which he traveled twice weekly. On several occasions he was called upon to deal with kahunas. Unfortunately, during this period his health began to fail. As a result, early in 1936 he returned to Boise where on October 10, 1936, he died at the age of 38.



It is the writer's belief that his great love was teaching, and that as a result of his illness his return to the Mainland was prompted by a desire to go back to that world which he had left behind.

Written by THOMAS D. MCCALLA,
son of Dr. Randolph McCalla.

Notes and News

HENRY N. YOKOYAMA, M.D.

HAWAII MEDICAL JOURNAL

Life In These Parts

The following surgeon-nurse colloquy was heard on Aku's program: " 'Gauze' . . . *'Gauze'* . . . 'Forceps' . . . *'Forceps'*, 'Scalpel' . . . *'Scalpel'*, 'Ouch!' " We are reminded of orthopod **Don Maruyama** who slashed his thumb with his own scalpel when a reluctant patella snapped back during surgery, but who played better golf with his bandaged left thumb sticking out prominently "like a sore thumb." (As the cliche goes. . . .)

We met **Edmund Ing** looking not a day older than he did 15 years ago and inquired what his secret was. Ed replied, "Play some golf, take it easy, and push yourself away from the table."

The PR Committee had proposed a Consumer's Board of lay members and physicians to discuss medical fees and other related problems. Someone suggested that this may lead to a volatile situation but our red haired philosopher-humorist **Claude Caver** squelched this with his usual aplomb, "A volcanologist was asked if a certain volcano would erupt. He prudently replied, 'It may erupt, but on the other hand, it may not.' "

Tom Thorson says: "A committee's composed of people who do nothing one by one, but collectively conclude that nothing can be done."

The Queen's Death Conference protocol read as follows: "A 34 year old female alcoholic died postop. . . ." Our editor **Harry Arnold, Jr.** who prefers the term *woman* to *female* argued, "A female can be a papaya tree, a Mediterranean fruit fly or a Dalmatian bitch."

A 62 year old Hawaiian woman was admitted with chest discomfort, dizziness, visual blurring and verbal aphasia. The attending physician, **Tom Fujiwara,** admitted, "It's difficult to ascertain the nature of the dizziness." The intern **Walter Weber** reported, "After a long session, the neurosurgeon was just as confused as she was." (Poor **Tom Sakoda** . . . seems to be an occupational hazard.)

Popularity note: "Kuakini Makai III votes Dr. **George Suzuki** Popular Physician for July." Some admirer added, "We dig his glasses."

QUOTABLE QUOTES . . .

Charley Ching's original term for Japanese plant miniatures: "Banzai plants."

Grant Stemmerman's favorite Appalachian expression: "He'll pick the eyes off a dead cat."

Lederle Symposium

Somehow the title, "A Symposium of Crises in Today's Society" was not appealing enough to give up a perfectly beautiful August Sunday, so with some misgivings, we peeked in to see what it was all about with a ready excuse for a fast departure. But then, we were pleasantly surprised to find first rate speakers and subject material and so stayed.

Mitchell Zavon, a medium statured, sharp featured, well barbered, professor type with a low, but well modulated voice, is professor of industrial medicine at Cincinnati. In his first talk, "Our Polluted Environment," he pointed out that medicine has long recognized the impact of environment on disease; in fact as long as the Hippocratic Classic, "Airs, Waters and Places." In his next talk, "What About Food Scares?" Mitchell pointed out that modern agricultural methods require the use of fertilizer and pesticides, some of which inevitably appear in our diet. More chemicals are required for storage and distribution of food stuff. Since 1959's "cranberry episode," we have had repeated scares about our food supply, but after the headlines, it is difficult to determine how much hazard actually existed; eg in monosodium glutamate, cyclamates, saccharin, nitrites, nitrosamines, etc. "The pesticides in foodstuffs are in such low concentrations that there is no need for worry. . . . Because of over reaction in this country, we are laughed at by food technologists in other countries. . . . This is over reaction to newspaper reporting and Naderism. . . . It's time we called a halt to these witch hunts especially by the FDA and not over react. . . ."

In another talk, "Diseases of Dirty Air," Mitchell stated that there is a host of naturally occurring and man-made pollutants, but plant pollen is by far the most pervasive pollutant associated with diseases. The effects of sulfur dioxide, nitrogen oxides, carbon monoxide, particulates, and other air pollutants are not as clearly associated with diseases. Personal air pollution from smoking tobacco remains a serious cause of disease.

Cecil B. Jacobson who is assistant professor of OB GYN at Washington University is a youngish, bespectacled, rotund, rapid speaker with spontaneous humor and ample slides. In his first talk, "Environmental Influences on Future Generations," Cecil feels it is critical to separate transient toxicity from permanent damage. The geneticist can monitor environmental mutation and evaluate the potential effects on unborn generations through chromosomal analysis. Most chromosomal errors are environmentally induced.

In his next talk, "Obstetrical and Gynecological Problems Related to Our Current Environment," Cecil related that the majority of reproductive anomalies are due to gametic aging, infectious exposure, drug or other chemical exposure, irradiation or other energy sources and pollutants, toxins and other environmental contaminants. "In genetics, what is apparent is not real and what is real is not apparent." He admitted that mothers-in-law are excellent geneticists.

Beverley T. Mead, a gruff voiced, hulking humorist with a shock of silver gray hair and bushy browed is chairman of psychiatry and neurology at Creighton. In his first presentation, "Illnesses of Noise and Crowding," he felt that there are subtle changes in the overall physiological function and emotional stability of people subjected to an excess of discordant noise. We can produce anxiety by causing anyone to respond to more stimuli than his capacity permits. But crowding can be more serious than noise. All psychiatric illnesses are basically related to the problem of getting along with other people. Crowding can be a factor in atherosclerosis, hypertension, and in a variety of respiratory, GI and other physiologic disorders.

In "Early Recognition of the Potential Drug User," Beverley says the most important sign is a changing personality, although the common signs are that of a change of companions, furtive habits, red eyes, strange breath, etc. Most important is recognizing the circumstances leading to drug abuse. In the potential abuser, removing stress and improving communication can pre-

vent abuse. To the question, "Why?" Beverley says, "I use drugs too. . . . I take alcohol every day. . . . This changes my reaction to environment so that the problems are not so big . . . and social relations are less strained. . . . Then why am I not an alcoholic? Because by definition, an alcoholic is 'A man who drinks more than his doctor'. . . . The characteristics of a drug abuser are the characteristics of a misfit *viz* one who is not accepted by his family, who does not relate to school, and who is not accepted by his peer group. . . . How to accomplish more than father did. . . . This concept of each generation standing on the shoulders of previous generations causes problems. . . . Growing up leads to greater problems . . . eg Charley Brown to Linus: 'Why suffer these anxieties?' Linus: 'So you can suffer bigger anxieties.'" . . . "**Margaret Mead** defines adolescence as the transition from total dependence to complete independence. . . . Those who need to assert themselves and contact environment more use alcohol or speed; those who need to get away and are bored resort to LSD. . . . The Irish have more alcoholics than any other group . . . they are good fighters, but have a poor army; they are romantics, dependent, defensive and need to drink in social, noisy environments. . . . The Jews are unhappy; they are poor fighters, but have a good army; they are compulsive, conforming, ritualistic. . . . They make poor alcoholics, but good narcotic addicts. . . . The orientals are close to the Jews. . . . They make poor juvenile delinquents and there are few alcoholics. . . . Ghetto kids begin with glue sniffing, go on to alcohol, then to barbiturates and heroin. The affluent kids use marijuana and LSD. . . . The primary danger sign is personality change. . . . Correction should not be in a punitive way. . . . There must be a positive approach. . . . Punishment does something for the punisher, but absolutely nothing for the punishee."

* * *

During the panel discussion, **Cecil Jacobson,** when asked what to do with the chronic aborter, said, "This is a test of your worth as a doctor. Do you pacify people or treat them? Give Provera in an area she holds dear. It hurts and she pays for it. I recommend tissue cultures for chronic aborters for this gives the same reinforcement as a shot of Provera."

Beverley Mead, when asked if noise could cause atherosclerosis, simply answered "Yes." When asked, "What is the effect of rock music on study habits," he digressed, "Sound can be soothing. What the heck do you think a lullaby is. . . . Its soothing and reassuring." Cecil Jacobson added, "Infants sleep better with music and tissue cultures grow better." **Mitchell Zavon** was contrary: "In Sudan where there is a noiseless environment, there is less presbycusis. The 60 year olds have the hearing of 30 year olds."

When asked about colon cancer, Cecil Jacobson replied, "Colon Ca is highly hereditary. . . . Start sigmoidoscopies at age 30 and every 3 to 5 years." Mitchell Zavon added, "There is some correlation of refined sugar and Ca of the lower bowel."

Mitchell Zavon was critical of the FDA. "The FDA removed cyclamates. Why? Washington is where all the hysterics go. It is a combination of science, pseudoscience and politics."

* * *

The post luncheon speaker was Beverley Mead at his best. He was introduced by **Michael Hase** who related the story of the premarital examination. . . . A girl wanted the usual contraceptive pills and marriage pamphlet after the examination. Later, she returned and complained. "That pamphlet is strictly for beginners," and with the superciliousness of a veteran remarked, "Your pill doesn't work. . . . It keeps falling out. . . ."

Before starting in on the institute of marriage in his talk "How to be Happy though Married," Beverley Mead first joked about his own first name. "You know how you get to a meeting. . . . Everyone calls each other by their first names. . . . 'Hi Joe,' 'Hi Bob,' 'Hi Jim,' but when they get to me, they say, 'Hi, uh uh Dr. Mead,' I'm the only guy recognized with a professional rank. . . ."

Herein are a few "Meadisms":

On marital difficulties:

"The trouble is, not all is from the apple in the tree; much is from the pear on the ground."

"I'm not against marriage. . . . I myself have had 14 happy years out of 21. I'm still in love with the same girl. . . . So far the wife hasn't found out."

"A MD's son came home unhappy and complaining about the office nurse to his mother . . . 'I know dad hates her too. . . . I wish I could grab her by the hair and bite her on the neck like daddy does. . . .'"

"Three superficial motivations for early marriages which don't work: *Escape* (with dissent). They have no goals and get married to find a goal. *Pregnancy*. A marriage that begins with pregnancy never works and the person who suffers most is the innocent child. Everytime they see the child, they'll think to themselves, 'If it hadn't been for this twerp . . .' *Love*. Just because you love a person, doesn't mean he or she is mature, responsible or considerate. Love is blinding and is no great respector of character and maturity. . . . Marriage based on love, and lacking maturity won't work. Love is an emotional, selfish and neurotic kind of thing."

"My advice to a woman: See how his father treats his mother. My advise to a man: See how her mother treats her father. Moreover, you can also see how he or she will look in 30 years."

"A woman needs a 'hearts and flowers' technique. For example men should practice saying 'I love you' so it sounds sincere, even if he doesn't mean it."

"The universal neurosis of women is attention. . . . They need to be told how pretty they are. . . . The universal neurosis of men is masculinity. . . . Wives are pretty good at raising their masculinity: eg 'Go in there and fight,' 'Go in there and ask for a raise.' But don't destroy this image by mothering . . . eg 'Be sure to take your umbrella.'"

"There is a great deal of communication difference between men and women. . . . Women talk more. . . . This is not a personal opinion. . . . This has been measured scientifically. . . . And, they don't have to stick so slavishly to the subject . . . eg wife could say suddenly, 'I don't think he should have done that. . . .'"

"The matter of subtlety also leads to problems. . . . When the wife employs the 'You-know-what-you-did' routine, the best ploy for the husband is to say, 'I planned that as a surprise, but now you know.' Wife: 'What do I know?' Husband: 'You don't know? Well, then, I won't tell you.'"

"Men generally are not communicative enough. . . . They usually maintain the strong silent type image. . . . But women need words of approval . . . words of endearment. Even during sex, the husband could at least say, "Ummmmmh! Ummmmmh!" This same rugged determination keeps men from asking directions at service stations. . . . He keeps right on driving east when all signs say west. . . . The wife can suggest: 'Honey, I think I see the setting sun ahead. . . .'"

"A little fighting is good now and then. It acts as an escape valve . . . but keep it verbal. . . . Keep it private. . . . No fisticuffs. . . . No grudge matches."

"In-laws are fine if they're across town. . . . When a wife says, 'My mother says you're effeminate,' the husband can retort: 'Yes, compared to her.'"

"A couple sees their priest. . . . It is Holy Week. . . . 'We were going to avoid sex, but couldn't hold out.' Priest: 'That's all right.' Couple: 'We were afraid you would throw us out of church. . . . They certainly threw us out of the supermarket.'"

continued page 426

New Members



Stanford K. W. Au, M.D.
1040 South King Street, Suite 401
Honolulu, Hawaii 96814
NEUROLOGY
Washington University—1963
Internship—University of Mianesota
—1963-1964
Residency—University of Minnesota
—1964-1966



Thomas M. Cashman, M.D.
888 South King Street
Honolulu, Hawaii 96813
PEDIATRICS
New Jersey College of Medicine—
1962
Internship—Walter Reed
General Hospital—1962-1963
Residency—Brooke General
Hospital—1963-1965



Simon S. Y. Cheng, M.D.
1441 Kapiolani Blvd., Suite 415
Honolulu, Hawaii 96814
INTERNAL MEDICINE
University of Hong Kong,
School of Medicine—1963
Internship—Queen Mary Hospital,
Hong Kong—1963-1964
Residency—Queen's Medical
Center—1967-1969, 1970-1971



Hiroshi Ikeda, M.D.
98-1010 Moanalua Road
Aiea, Hawaii 96701
INTERNAL MEDICINE
Jikei University
School of Medicine—1947
Internship—Vassar Bros. Hospital,
Poughkeepsie, N.Y.—1962-1963
Residency—St. Francis Hospital—
1963-1966



Robert L. May, M.D.
888 South King Street
Honolulu, Hawaii 96813
RADIOLOGY
Case Western Reserve University—
1963
Internship—Kaiser Foundation
Hospital, S.F., California—1963-1964
Residency—University Hospitals
of Cleveland—1966-1969



Philip I. McNamee, M.D.
888 South King Street
Honolulu, Hawaii 96813
OBSTETRICS-GYNECOLOGY
Stanford University—1962
Internship—Wm. Beaumont
General Hospital—1962-1963
Residency—Womack Army Hospital
—1963-1964
Tripler Army Hospital—1964-1967

HAWAII MEDICAL JOURNAL



W. Dawson Durden, Jr., M.D.
888 South King Street
Honolulu, Hawaii 96813
GASTROENTEROLOGY
Emory University—1957
Internship—Martin Army Hospital —1957-1958
Residency—Letterman General Hospital—1958-1961
Walter Reed General Hospital —1965-1966



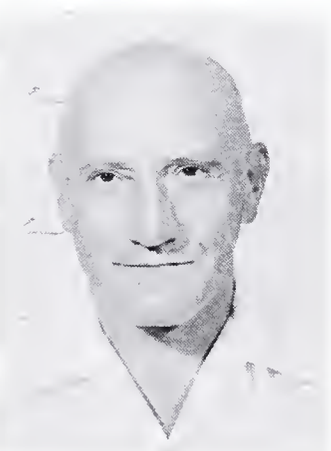
Philip D. Hellreich, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
DERMATOLOGY
State University of New York, Upstate Medical Center—1966
Internship—U.S.P.H.S. Hospital, Staten Island, N.Y.—1966-1967
Residency—U.S.P.H.S. Hospital, Staten Island, N.Y.—1967-1969



Robert C. Hinman, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
NEUROLOGY
University of Chicago—1961
Internship—University of Illinois Research & Educational Hospital—1961-1962
Residency—University of Michigan—1962-1964
University of Michigan—1964-1967



Shozo Ogawa, M.D.
2065 South King Street
Honolulu, Hawaii 96814
INTERNAL MEDICINE
Kobe Medical College—1959
Internship—U.S. Naval Hospital, Yokosuka, Japan—1959-1960
St. Francis Hospital, Poughkeepsie, N.Y.—1960-1961
Residency—Jewish Chronic Disease Hospital—1961-1962
V. A. Hospital—1969-1970
Queen's Medical Center—1970-1971



Herman V. Platt, M.D.
P. O. Box 606
Hilo, Hawaii 96720
INTERNAL MEDICINE
Georgetown University—1942
Internship—Cedars of Lebanon Hospital—1942-1943
Residency—USAAF General Hospital, Ft. George Wright, Spokane, Washington—1943-1945



Ignatius M. Segovia, M.D.
888 South King Street
Honolulu, Hawaii 96813
ANESTHESIOLOGY
Valencia University Medical School—1951
Internship—Presbyterian Hospital, Philadelphia—1953-1955
Residency—Presbyterian Hospital, Philadelphia—1958-1959

County Society News

HAWAII MEDICAL JOURNAL

Maui

A combined meeting with the Maui Pharmacists Association was held on July 20. Mr. Jerry Estavillo from the Drug Department of the State Department of Health spoke on the new drug laws and requirements for physicians and pharmacists. He pointed out many restrictions concerning new federal control on drugs. Mr. Estavillo said that many physicians have not properly filled out the new forms for their narcotics number. Additional forms are being sent out, and new numbers may be issued after August 1. It was felt by many present that the regulations placed a severe burden on physicians and pharmacists while ignoring the large amount of illicit drug traffic in our country.

A symposium on Grief and Dying will be held at the Maui Beach Hotel on August 26 and 27. Mr. Tom Thorson notified the Society that a speakers workshop will be conducted at the AMA Speakers Bureau meeting on Maui September 4 and 5.

Dr. Iaconetti asked the Society if they wished to host the next State Medical Convention. A questionnaire will be sent to all physicians requesting their opinions on the matter.

Honolulu

Approximately 200 members and guests were present at the May 4 meeting.

New member, Dr. George Murdock, was introduced to the membership.

A moment of silence was observed by the membership for Dr. Keith Kuhlman who died on April 12, 1971.

Dr. Edward Lewis, Jr., Chief Medical Officer of the Bureau of Narcotics and Dangerous Drugs of the Department of Justice discussed the new federal regulations concerning inspection and control of narcotics and dangerous drugs under the Controlled Substance Act of 1970. Assisting Dr. Lewis in his explanation of the new requirements was Mr. Robert Fukuda, United States Attorney. The physicians were informed that the deadline for application for registration had been extended to August 1 and that any questions regarding the new regulations should be directed to the attorney general's office.

Presiding over the PMMS award drawing was Bob Glein of Control Data Corporation who presented $500 worth of PMMS service to the lucky winner, Dr. Vernon Jim.

Hawaii

Dr. Herman Platt was elected a member at the July 22 meeting held at the Hilo Hotel. Sixteen members attended.

Guest speaker was Dr. George Starbuck, Assistant Professor of Pediatrics, University of Hawaii, and Director of Protective Services for Children. He gave an interesting and informative talk on child abuse with special emphasis on current cases in the islands.

MAY WE HELP YOU

TO HELP YOUR PATIENTS?

Complete Line – Orthopedic Supports
Artificial Limbs – Invalid Equipment

Certified Fitters

C. R. NEWTON CO. LTD.

1575 S. BERETANIA STREET
HONOLULU, HAWAII 96814
TELEPHONE 949-8389 OR 949-6757

Hawaii Medical Association

HAWAII MEDICAL JOURNAL

COUNCIL MEETING

August 20, 1971—5:00 p.m.
Mabel Smyth Conference Room

PRESENT

Dr. Herbert Y. H. Chinn, presiding; Drs. William E. Iaconetti, John J. Lowrey, Theodore T. Tomita, Grover H. Batten, William W. L. Dang, H. William Goebert, Jr., Sakae Uehara, Cesar B. deJesus, Winfred Lee, Calvin C. J. Sia, Charles Judd, Jr., J. I. F. Reppun, J. Mark B. Sowers, Rowlin Lichter, and Don Poulson; Mrs. Helen Fujita, Messrs. V. Thomas Rice, Tom Thorson, Jon Won, and Tom Leineweber.

CALL TO ORDER

The meeting was called to order by President Herbert Y. H. Chinn.

MINUTES

The minutes of the May 28, 1971 meeting were approved as circulated.

COMMUNICATIONS NOT REQUIRING ACTION

(1) Resolutions from the Hawaii Chapter, American College of Surgeons, and a similar one from the Hawaiian Surgical Association, were received expressing their willingness to assist in any way possible to continue doctor participation in perpetuating the Health Fair. Copies were also sent to the Board of Governors of the Honolulu County Medical Society.

(2) Letter of thanks and return of $200 from Dr. Roy Kuboyama, chairman of the School Health Committee, for the donation from HMA for the recent Sports Medicine Workshop.

REPORT OF THE TREASURER

HMA's Financial Statement as of June 30, 1971, was presented. It was moved, seconded, and passed to approve the Treasurer's Report subject to audit.

UNFINISHED BUSINESS

School of Public Health Proposal: Dr. Lowrey gave a progress report on the feasibility study dealing with the health delivery system in Hawaii initiated by Dr. Edward O'Rourke of the School of Public Health. So far there have been six informative meetings. It appears they are planning on organizing a library of medical and socio-economic studies. A preliminary report on the project has been sent to Washington, D.C. Dr. Lowrey was given a copy of the program report which Dr. Larkin sent to him for comments. Dr. Lowrey also discussed the need for a member of the HMA to be represented on the Health & Community Services Council of Hawaii which will be making the study. The HMA Council was notified that Dr. George Mills is the Association's representative to this Council.

WORKMEN'S COMPENSATION

The newly promulgated Regulation XXXI Relating to Workmen's Compensation Law released by Mr. Robert Hasegawa of the Department of Labor and Industrial Relations was effective as of August 13, 1971. If an appeal is to be made, it should be made within 30 days after the effective date of the Regulation. Because of the shortage of time the Council met to discuss whether the HMA should appeal the Regulation.

In a memorandum to all HMA members, the President invited doctors having opinions on the Regulation to appear before the Council and to express their feelings. At 7:45 p.m. about forty HMA doctors met in the Mabel Smyth Auditorium to discuss Regulation XXXI. Those doctors other than Council members who offered opinions either personally or as representatives of their specialty societies were: Virgil Jobe, representing radiologists; Don Poulson, representing neurologists; Eldon Smith, anesthesiologists; Frederick Dodge, representing general practitioners; Jack Ikeda, representing internists; and J. I. F. Reppun, Robert Millard, Carl Johnsen, Rowlin Lichter, and Douglas Bell, II, representing themselves.

The Council reconvened to determine what course of action the HMA should take regarding Regulation XXXI.

ACTION:

Motions were made, seconded, and passed to:

(1) Appeal Regulation XXXI.

(2) Direct the Legislative Committee and the Workmen's Compensation Committee to formulate legislation to incorporate the usual and customary rates and to withdraw any artificial division of classes of physicians.

(3) Appeal Section 1(b) in Regulation XXXI relating to the definition of a "specialist."

(4) Request change in the wording in Section 2(b), second sentence, by striking out the word "may" and inserting "shall" to read:

. . . "competent medical advice" *shall* include advice from a panel of at least three physicians or surgeons selected by the director after consultation with the Hawaii Medical Association and convened for the purpose of this subsection.

(5) Delete the last sentence in Section 3 relating to medical examination by employer's physician.

(6) Amend or delete (ii), (iii), (iv), of Section 6(3) "Rules of Decision for Surgery Services" according to prevailing practice.

(7) That we have a combined Legislative and Workmen's Compensation Committee's recommendation regarding legislation to develop a UCR concept and to correct any deficiencies as noted by the Counsel.

(8) That the HMA President be authorized to call a special meeting of the House of Delegates when in his judgment there is cause to do so regarding the Regulation.

NEW BUSINESS

Health Maintenance Organization (HMO): Dr. Iaconetti gave a report concerning the development of a HMO on Maui. On August 3, 1971, a definite proposal was given the Maui Medical Group by HMSA to develop a HMO on that island. The proposal lists the responsibilities of the Maui Medical Group. It was pointed out that it was started with the concept of putting this under the County Medical Society; however, HMSA preferred to start with an established business such as the Maui Medical Group.

Experimental Medical Care Review Organization (EMCRO): The Study of the Cost of Quality Care was discussed. Dr. Chinn requested Council approval to sub-

continued page 424

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: NOEL D. EVANS, *Vice President:* EDMUND E. EHLKE, *Secretary:* LAUREN WONG, *Treasurer:* MARION CHONG, *Board of Directors:* NELLIE CHANG, WALTER HARANAKA, JAMES MCELHANEY, EARLE SANDISON, HON TING CHEE, BEN CHOCK, WILFRED OGOMORI and BETTY BELL.

Third-Party Prescription Programs—Present Judicial Interpretations of the Sherman Antitrust Act and the Profession of Pharmacy. "Discrimination"? What do you think? What will you do to help?

Ralph Engel, Director of the National Pharmacy Insurance Council, Dr. J. Curtis Nottingham, Chairman of Board of Governors NPIC, S. Chester Oppenheim, NPIC Special Council, and James S. Eden, Akron, Ohio pharmacist, *"Told it like it is"* as they presented testimony to the Subcommittee of the Select Committee on Small Business of the United States House of Representatives, July 8, 1971. Representative William L. Hungate (D-Mo.), Subcommittee chairman.

Portions of their very commendable testimony has been extracted and quoted for your consideration and personal action.

Eighty-five percent of our population is presently protected by one or more forms of private health insurance, yet only 2% is covered by a drug benefit program. Why? Four basic reasons follow:

1. For most people the risk of large hospital and/or doctor bills held more serious consequences;
2. Drug coverage generates a huge number of claims, increasing administrative expenses beyond that which is practical, considering the amount of each claim;
3. Only one out of 10 insured will utilize hospital coverage; two out of three will use drug benefits: providing a higher risk health service from the point of wide-spread utilization;
4. The existing judicial interpretations of the antitrust law constitutes a major deterrent to equitable and compensatory reimbursement for pharmaceutical services.

Despite the above deterrents the clamor for outpatient drug insurance grows.

There are two basic ways drug expenses can be covered, the inclusion of drug benefits in established prepaid medical plans; ex. Kaiser Foundation Health Plan, major medical insurance plans, or the development of prepayment plans exclusively to cover drugs; ex. Paid Prescriptions, Prepaid prescription plans, etc. Both service benefit arrangements: (vendor is paid by third party) and indemnity type arrangement, (patient pays directly for service and is then reimbursed by third party) cover prescriptions dispensed. In the majority of presently existing drug benefit plans, a portion of the medication payment is made through a deductible or a co-insurance factor. In 1970 private, negotiated and government drug plans covered only 10% of the 1.5 billion prescriptions dispensed in the United States; in 1975 some 50%-60% of a projected 2.5 billion prescriptions dispensed will be covered. Should National Health Insurance come to pass, the percentage could easily jump to 95%.

"As prepaid prescription programs proliferate, they will continue to produce a substantial impact on pharmacy.

"The profession felt some mechanism was needed through which it could address itself to the problems created by such programs and through which it could present a unified approach to many of these problems.

"The American Pharmaceutical Association conceived the National Pharmacy Insurance Council, believing that the best interest of the public and pharmacy would be served if the profession had a voice which could speak with authority in the prepayment area.

"The National Pharmacy Insurance Council was organized in October 1969. Forty-six (46) state associations are represented on the Council as well as the American College of Apothecaries, the American Society of Hospital Pharmacists and the American Pharmaceutical Association."

"The activities of the National Pharmacy Insurance Council fall within three (3) general categories—*liaison, research,* and *education.*

LIAISON

"Broadly stated, the liaison activities are designed to develop administrative procedures which will insure the delivery of pharmaceutical services to beneficiaries with efficiency and economy.

"Specific activities include efforts to develop a uniform system or procedure for receiving and processing claims for pharmaceutical services as well as identification of pharmaceutical services that contribute to optimal therapeutic utilization and the development of an equitable and feasible system for reimbursing pharmacists."

RESEARCH

"Research activities are concentrated in two primary areas—health care and socio-economic research.

"In the area of health care research, anticipated projects will seek to develop and test new methods for improving the delivery of pharmaceutical services, particularly in connection with third-party programs.

Socio-economic research is conducted in large part to adequately inform others about the economic structure of pharmacy in the several forms in which the practice is consultation, group practice, etc. Such information is essential so that underwriters can exercise independent but informed judgments about the costs of providing pharmaceutical services.

EDUCATION

"The educational activities of NPIC are directed at four major segments of the population—(1) pharmacists, (2) underwriters, (3) sponsors and (4) the public."

Now that we have traced the development and growth of third-party drug programs, their scope and impact, it is time to address ourselves to the inability of pharmacists and their associations to respond effectively to the massive development of third-party payment prescription benefit programs in the private sector.

"In the private sector of third-party prescription drug plans, the prohibitions of the antitrust laws constitute a major barrier to securing for the pharmacist equitable and compensatory reimbursement for pharmaceutical services rendered in dispensing prescriptions. Under existing judicial interpretations of the antitrust laws, any association is absolutely precluded from negotiating or bargaining with the third-party carrier with regard to the

contractual formula for determining the dollar amount of the participating pharmacist's reimbursement.

"Two prime antitrust risks dangle like the sword Damocles over the heads of pharmacists. One is the antitrust charge that concerted action by an association of pharmacists in bargaining with the third-party insurer with respect to reimbursement is an illegal *per se* price-fixing agreement among competitors in violation of Section I of the Sherman Act. The other is the antitrust charge that any action by an association of pharmacists, which approves or rejects a particular third-party plan, constitutes an illegal *per se* group boycott, also in violation of the Sherman Act.

"Since proof of illegal price-fiixing or a group boycott in almost every case is based upon circumstantial evidence, it is clear that the safest course for avoidance of antitrust violation hazards leaves the pharmacist in the unrealistic and injurious position of being compelled to decide individually and unilaterally whether or not he should become a contractural participant in the third-party offered plan.

"This obviously confronts the individual pharmacist with a Hobson's choice of "take it or leave it." Considering the reality that third-party plans have spread nationally to cover a massive proportion of filled prescriptions, the individual pharmacist is under economic duress either to participate in such plans or face the possibility of losing his professional practice.

"This Subcommittee of the House Select Committee on Small Business, whose prime objective is to preserve the independent small entrepreneur, whether he is a businessman or a professional, will readily see that, as applied to third-party drug plans, the antitrust ban on concerted or collective bargaining by pharmacy associations creates a monstrously inequitable imbalance of economic power. No single pharmacist or pharmacy is a bargaining match for any mammoth insurance company, the large-scale employer or Blue Cross/Blue Shield insurer—these being among the primary sponsors of third-party programs in the private sector."

"NPIC respectfully submits that what is urgently needed as effective relief from the antitrust dilemma facing pharmacists is an amendment to the Sherman Act and Section 5 of the Federal Trade Commission Act which would sanction negotiations by a pharmacy association with either a governmental or private sponsor of third-party prescription programs. Such an anti-trust exemption should be narrowly circumscribed and subject to appropriate safeguards against misuse so that the only collective negotiations authorized will be those directly ancillary to the reimbursement provisions and administrative processes related to reasonably prompt payment.

"Another area of great concern is the added administrative burden placed on the pharmacist under third-party programs. The added paper work brought about by claims processing has become an increased burden both financially and physically. A great deal of time is consumed in dispensing a third-party prescription as compared to a private prescription and the pharmacist is not being compensated for the difference.

"A number of programs place the responsibility for determining the patient's eligibility to receive medication upon the pharmacist. Some think they are aiding the pharmacist in making his decision regarding eligibility by providing a multiplicity of color coded cards, each signifying various types of coverage, or a "hot list" noting the eligibles, when in reality they are making increased demands on the pharmacist's time."

"Another area of great concern is the level of compensation given the pharmacist for the services he renders. Historically, pharmacists have determined their charges for pharmaceutical services by a number of methods, the most common being percentage markup, professional fee or a variation of both.

"The term 'markup' describes the method whereby a pharmacist combines the product cost along with a fixed percentage of that cost to arrive at the charge to the patient.

"The fee method is a single sum added to the acquisition cost of the medication. The fee should include all overhead expenses beyond the product cost and the pharmacist's compensation.

"As insurance companies and state welfare administrators became involved in the service benefit type of drug problems, it became necessary to develop policies concerning methods of reimbursement. Initially, many utilized what is termed the 'usual and customary' approach. Using this method, they reimbursed the provider the charge which he himself established.

"Although the 'usual and customary' approach can apply to a fee as well as the markup method, many pharmacists still utilize the percentage markup procedure, and therefore the terms 'usual and customary' have erroneously grown synonymous with this method. From an administrator's view, this procedure has proved unworkable, as there is no fiscal control over reimbursement and the program costs escalate."

"Dr. T. Donald Rucker, Chief of Drug Studies Branch, Division of Health Insurance Studies, Office of Research and Statistics, U.S. Social Security Administration, has characterized the ideal reimbursement formula to be simple, responsive, neutral, adequate, valid, discriminative, effective, precise, inclusive and practical—plus having the ingredients of vendor acceptance on the one hand and administrative feasibility on the other. The former is crucial since a pharmacist with major reservations about the reimbursement mechanism is not likely to provide that continuous cooperation which is necessary for the program to successfully achieve its goals. Administrative feasibility, the second factor of a practical formula, is required in order that a drug program can realize the particular objectives which its clients anticipated when they joined together to purchase prescription drug benefits.

"*Simplicity* is essential so that the vendor comprehends the basis on which he is being paid. The system should not inundate the provider with paper work.

"The formula should be *responsive*. The costs of operating a prescription department vary and the reimbursement structure should be able to reflect these increases or decreases.

"The concept of *neutrality* is most important. The formula should not favor one type of pharmacy over another (discount houses over community outlets or vice versa).

"The remuneration level built into the system must be *adequate*, in that it covers those necessary overhead expenses directly related with the dispensing of prescription drugs.

"The formula should measure realistically and consistently the dispensing expenses of many profiles of phamacies in different regions of the country.

"Another attribute is that the procedure be *discriminative*. That is, it should have the ability to differentiate beween vendors whose necessary costs of dispensing vary because of regional, economic, and management differences.

"The ideal formula should also be *effective*. In this respect, we mean that the pharmacist should be stimulated continually to seek more efficient ways of rendering dispensing services.

"Still another feature of the system concerns its ability to measure *precisely* those overhead expenses associated with the dispensing of prescriptions."

Your Hawaii Pharmaceutical Association has the questionnaire from the Kansas program and with your cooperation will try to develop prescription dispensing cost information for Hawaii.

"There is still another problem facing pharmacists, that is, their inability to obtain reimbursement for the pharmaceutical services they provide. Just like physicians, hospitals and other providers, pharmacists must pay for for purchases and meet payrolls and other operating expenses.

"Generally, pharmacists do not have access to cash reserves which can be used for these purposes. When

forced to wait anywhere from three (3) to six (6) months for reimbursement of their claims, pharmacists frequently must borrow operating capital to meet their own expenses. The cost of borrowing, particularly at this time, is a significant expense—one for which the pharmacist is not compensated.

"Pharmacists are caught in another trap. Where states have run out of money for their Medicaid programs, their simplistic solution to the problem has been to impose an across-the-board flat percentage reduction on the claims of providers. The effect of such action on pharmacists is to virtually eliminate, or at least substantially reduce, the pharmacist's compensation for his services. To cite an example, it is not unusual for pharmacists to dispense prescriptions where the acquisition cost of the drug is ten dollars ($10). Assume that the fee established by the state is two dollars ($2), making the total reimbursement claim for the prescription twelve dollars ($12). If the total claim is reduced by fifteen percent (15%) or one dollar and eighty cents ($1.80), the pharmacist is left only twenty cents (20¢) compensation for his professional services after he is reimbursed ten dollars ($10) for his out-of-pocket cost of the drug.

"Pharmacists have also been without remedy and forced to absorb substantial dollar losses because of inadequacies in the system for the identification of eligible recipients. Thus, pharmacists have dispensed required medication on valid prescriptions, in good faith, only to have their claims rejected when it was later decided that the patient was not eligible."

Mr. Engel and his associates enumerated other problems of existing private and governmental programs—dispensing fixed quantities in excess of safe patient requirements encouraging drug misuse and abuse . . . the "Sales Tax Issue" in Michigan—Blue Shield flatly refuses to permit the collection of the tax from the patient—threatening to drop the pharmacy from the program if they don't comply, but the pharmacist *must* pay the tax.

"All of the problems that I have described are either exclusively or largely attributable to failings of program sponsors or fiscal intermediaries responsible for administration of these programs and their lack of understanding, and in some cases, concern about the profession of pharmacy and the unique problems experienced by pharmacists."

"Rather than discuss only problems experienced by pharmacy in connection with third-party programs, we would like to suggest a significant contribution we believe pharmacists could make to these programs and to prepaid prescription benefit programs generally. This contribution relates to the task of drug utilization review, which we believe is a necessary requirement for prepaid prescription programs. A formalized drug utilization review procedure will be necessary to insure that the highest quality health care is being provided patients in relation to program costs. Such a review procedure will also be necessary to control program costs.

We emphasize that the most important aspect of drug utilization review, and the one for which the pharmacist can make the greatest contribution, is in the assurance of rational drug prescribing and dispensing practices. At present, there is great concern among the professions of medicine and pharmacy, as well as among those responsible for the administration of health care programs, about the lack of rational prescribing evident in today's health care system.

"The object of rational prescribing is to provide the patient with the right drug in the right amount at the right time. From this definition, and the variables inherent in it, you can see that rational prescribing cannot be expected to flow from inflexible laws, regulations or statements of policy. What is needed is a viable review structure and process which can address itself to particular problems relating to particular drugs, particular diseases and practices. We believe that such a process includes the much discussed concept of "peer review" but goes beyond it, in that it contemplates a multi-disciplinary approach to the problem. It is in this multidisciplinary context that the pharmacist can and must function if drug utilization review is to achieve its objectives.

"Clearly, drug utilization review can be expected to consider program costs and administrative burdens. For many of the problems we anticipate, pharmacists are the best informed, if not the only source of required information. The pharmacy input is necessary, along with input from other health care professions, consistent with today's increasing 'team' approach to health care problems."

This writer certainly concurs with Mr. Engel's presentation. Your Association already has a Peer Review committee to assist you in solving the administrative, equitable and timely reimbursement problems with your medical fiscal intermediary, HMSA. Your committee is likewise available to HMSA to assure proper claim charges by pharmacists. It's your committee—use it!

Are you asking yourself—How can I help? Here's how.

Write to: Hon. William L. Hungate
Select Committee on Small Business
2361 Rayburn House Office Building
Washington, D.C. 20515

Tell him just how you feel about the need to amend the Sherman Antitrust Act in the interest of Pharmacy's ability to contribute meaningfully to the public health of prepaid drug benefit recipients with just remuneration for their services.

Write to Hawaii's legislators. Answer your Association's questionnaires on legislation, your cost of doing business. It's your profession—participate in the shaping of our future!

Federal Assistance to Pharmacy Schools

Pharmacy schools will participate in Mr. Nixon's drive to build up health care personnel via the Assistance Bill recently passed in the House. We will not receive comparable grants to medicine, dentistry or osteopathy as the administration sees no demonstrable need to increase the number on a crash basis. (Poor public relations on the part of the profession of Pharmacy. With the "Drug Abuse" clamor and ⅔ of all hospital patients admitted for chemotherapy, an estimated shortage of 70,000 pharmacists by 1975 sounds like demonstrable need to me. —ed.)

Pharmacy Economics

The Lilly Digest 1971 reflects the trends established by our national economic dilemma on the operations of the community pharmacy.

The average community pharmacy recorded a sales high in 1970 (3.6% greater than 1969) *but* the *net profit decreased to the lowest level since 1932.* (Only 4.1% . . . were it not for the pharmacist's dedication to the public health, his investment could better return him greater dividends by simple deposit in any of a number of insured S & L, banks, etc., with no trauma.)

Total expenses rose 4.6%—32% of sales—an all time high. Wages accounting for 20% of sales.

The Prescription department increased its share of sales to 44.5%.

The average Rx charge was $4.06.

Distributed by ????

So? *Who manufactured that product on your shelf?* You don't know? Why did you buy it? Cheap? I doubt it, if efficacy is compared to cost. Won't you review your inventory? Remove those items whose label doesn't bear the manufacturer's name. Such pig in a poke buying is an abdication of your responsibility as a pharmacist to preserve and protect the public health.

continued page 424

La Pietra

for those who have arrived . . .



Many prominent local families are moving into the completed La Pietra . . . and there are only a few superb 3 bedroom, 3½ bath **estate townhouses** available. On over **five acres** of enclosed security overlooking Kapiolani Park, La Pietra is your unique opportunity to enjoy the fee **simple** Diamond Head Location, the spacious air conditioned elegance, the carefree security of maintained grounds and an **entry guard** . . . and the handsome investment potential. Enjoy the amenities of individual home ownership and the benefits of condominium controls. See for yourself, your family just might be one of the fortunate few that will move up to La Pietra. $130,000 in fee simple with **generous financing** available and courtesy to brokers.

La Pietra Development Corporation

3083 La Pietra Circle
(off Poni Moi Road) *Phone 923-0464*

mit an application for funds through the Regional Medical Program.

ACTION:

A motion was made, seconded, and passed that the President be authorized to prepare a grant request for the Study of Quality of Medical Care, which grant request to be submitted to the Regional Medical Program and/or any other appropriate source of potential money.

Appointments on EMCRO Committees:

ACTION:

Motion was made, seconded, and passed to authorize the Executive Committee to make appointments of chairmen and membership on committees of EMCRO.

EMCRO News Release: The Association has been deluged with requests from the news media for information regarding the HMA Study on the Quality of Medical Care. It was pointed out that Dr. Payne and Dr. Anderson had planned on a press conference upon their return this Fall.

ACTION:

Motion was made, seconded, and passed that the matter of a press release relative to the HMA Study conducted by Dr. Payne be discussed with Dr. Richard Mamiya and that any press release be deferred until at least Dr. Anderson returns and the form of the press release be determined by both Dr. Anderson and the Executive Committee. The Executive Committee shall write a letter to Dr. Payne relative to the news release of the Study.

Rural Medicine: Dr. Winfred Lee reported that a committee of the Honolulu County Medical Society has been very active in promoting interest in practicing medicine in the rural areas of Oahu. There are now five doctors in the Waianae area due to the interest generated by this committee and there are indications of interest from several doctors as well. It was pointed out that Kahaluu is an area under experiment by St. Francis Hospital, but there was some question about the legality of allowing a resident to practice there and Dr. Lee was asked to look into the situation with Sister Maureen. Dr. Lee reported that Dr. Lawrence Winter has another doctor working with him in Kahuku.

Price Freeze: Mr. Thorson reported that the HMA Executive Office has had a number of inquiries from throughout the State relative to the "Executive Order" of August 15, 1971. Preliminary information is that President Nixon's Order does refer to professional fees. Compliance with the freeze is not voluntary—violation of the Order may be subject to a fine of $5,000 for each violation.

Peer Review: A preliminary draft of guidelines for the establishment of a Peer Review Committee was presented. Dr. Chinn requested the Council to read and digest these guidelines. He also distributed copies of "Shattuck Lecture—The Anatomy of Our Melancholy," by George Himler, M.D., for perusal. The subject of peer review will be brought up again at the next meeting of the Council in October.

ADJOURNMENT:

The meeting was adjourned at 11:00 p.m.

R. Varian Sloan, M.D.
Secretary
by Bess Chang

The recent Vitamin C recall by the FDA of some 16 manufacturers' and/or distributors' products of more than *164 million* sodium ascorbate containing tablets misbranded Vitamin C is a shocking realization of the greed and perhaps ignorance of some pharmaceutical manufacturers and/or distributors of good manufacturing practices.

We pharmacists can literally eradicate these parasites of human misery in the pharmaceutical industry by insisting on knowing the source of the manufacturer of every product we purchase, and buying only products manufactured by pharmaceutical firms that we know have consistently good records for the pursuit of good manufacturing practices.

Let's give the F.D.A. a hand. OK? Today!

The Perfect "Nose Drop" Still to be Developed

Those of us who have had the privilege of serving the community as pharmacists these past twenty years have seen patient after patient with chronic nasal congestion resulting from the misuse of nasal decongestants—nose drops—by whatever name. Whether prescribed or over the counter preparations, if utilized too frequently contrary to the physician's or package instructions, the rebound effect of the preparations can cause severe nasal obstructive symptoms.

Pharmacists can serve their patients meaningfully by taking an extra moment to emphasize the physician's instructions when dispensing nose drops. It is our direct responsibility to advise the patient of the side effects and specific directions for administration of over the counter nasal decongestants. Since self service displays of nasal decongestants do not lend themselves to the personalized attention of the pharmacist, careful consideration should be given to the O.T.C. products so displayed.

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

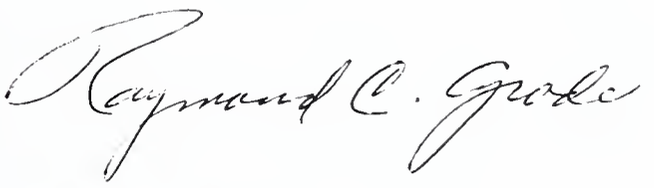
medicine is not a cut-rate field.

Too much is at stake to cut corners by cutting service. At Amfac you will find the lowest prices and the best terms consistent with the service you deserve and the standards you demand. Large, local stock. Fast, dependable four-times-a-day delivery service. 30 days to pay.

At Amfac medicine is not a cut-rate field.


MANAGER


SALES MANAGER — DRUG


MANAGER — MEDICAL EQUIPMENT

Amfac
DISTRIBUTION COMPANY
Drug Department
PHONE 533-0315

Notes and News *continued from 415*

Chauncey Leake—A Visiting Physician

To a Queen's Conference in September came **Chauncey Leake,** pharmacologist-philosopher-poet extraordinary. This venerable, white haired teacher with a friendly mien and a mildly cracking voice lists among his proud accomplishments memberships in the Kit Kat, the Chit Chat and Cosmos clubs (gleaned by **Bill Hartwell** while perusing his Who's Who listing). Harry Arnold, Jr. who introduced Dr. Leake was reminded of the woman's club chairman who introduced the guest speaker with: "He doesn't need an introduction for he has a Who's Who column 6 inches long." Chauncey Leake made himself comfortable forthwith saying, "My wife says to be proper, but I'm taking my coat off." and launched into a most delightful lecture on allergy, complete with slides and time lapse movies of allergic phenomena of nasal mucosa and spiced with his personal philosophy on allergy. The following are but a few anecdotes gleaned from the hour's talk:

"I sometimes don't realize how old I am . . . but I recently had my 75th birthday." Then with a twinkle in his eye quoted: "Little is left of youthful joys, but I'm glad for what remains."

On the subject of cell-destroying-free radicals, he punned, "I know we don't have free radicals, but I mean chemical free radicals. . . . Vit E sops up those chemical free radicals and slows up cell destruction. . . . We lose 50,000 brain cells a day, you know."

About the role of potassium iodide in allergy: "When you don't know what else to do for your allergy patient, give him potassium iodide."

"Aspirin is the most widely used agent next to alcohol. . . . We don't know how it works, but we're learning all the time."

"My thesis in allergy is swelling. . . . Relief of swelling is relief of allergic symptoms."

"When a mother calls late at night about her child's asthma acting up after receiving an epinephrine shot earlier, my advice to pediatricians is to tell the mother to rub the site of injection. . . . This releases more epinephrine and gives the child relief. . . ."

About Alexis Carrel's work on tissue culture for which he received the Nobel Prize. "He was a fake . . . I don't like him."

"Lots of great things are due to mistakes." (eg the demonstration of chromosomes in embryonic spleen cells back in 1915 because hypotonic solution was used by mistake.)

"Of all the sciences, medicine best brings together science and the humanities. . . . It is no coincidence that physicians are also artists, authors and poets. . . . I urge you all to maintain and promote your humanistic qualities for this leads to good judgment. . . . You must train that judgment to its fullest quality. . . . How to acquire judgment? . . . By practice. . . . Try something in the arts and humanities. . . . How many of you have tried to write poetry. . . . Nothing requires more judgment than to try to bring rhythm and reason together. . . ." With this introduction, Chauncey Leake recited four of his poems, "Truth and the Revolving Nucleus," "Sensitive Inside of Noses," "Cancer" and "Evolution and Thermodynamics." The lecture had gone into overtime, but no one left . . . all thoroughly spellbound.

Dialogue From Aetna Medicare Review Meeting

The Whaler's Broiler reverberated to the problem, whether to pay or not to pay for routine admission EKG's. Our genial Aetna Medicare director **Bob Grathwohl** had announced that the Washington office had decreed that routine EKG's would not be allowed. **Bernie Fong** fought tooth and nail and announced that 90% of routine admission EKG's he reads at Queen's have some abnormality and certainly, all medicare age EKG's would be abnormal. **LQ Pang** who has attained medicare age took this as a personal affront: "I may be arteriosclerotic, but my EKG's are normal." **Ted Tseu** teased: "Wanna bet?" **Gabe Ma** added fuel to fire by concurring with Ted. LQ bristled: "I'll give you odds that my EKG's are better than yours." (When last heard, Gabe and LQ were deciding how many golf balls they were wagering.) The question arose about how frequently should EKG's be done . . . Our medical philosopher **Bernie Fong** made a statement which should become a medical classic: "What may be necessary for one doctor may not necessarily be necessary for another." Since routine EKG's are not allowable, Bernie recommends multiple diagnoses including 'r.o. ASHD" so the EKG's will be allowable. "I usually put down my routine eight diagnoses . . . with a rubber stamp."

Between the chart sessions, **Jerry Faulkner** and **Nial Scully** discussed the cholesterol lowering properties of Maui onions which they had each ordered a plateful of. Cholesterol conscious Jerry with a mouthful of tenderloin and onion slices was heard to say, "I kin just see those cholesterol molecules being squashed by these onions."

New member and allergist, **Allan Young,** had a pile of problem allergy cases to review. Allan complained to chairman Gabe Ma: "For a new guy, you sure loaded me up. When you approached me, I envisioned a dozen fresh oyster, and I come today and no oysters." (The shipping strike was certainly having its adverse effects on the temperament of the review committee members.)

FROM TOM THORSON'S CORNER . . .

Father O'Brien, about to die, called Father Callahan in to make a death bed request. . . . "When I am gone, take that good Irish whiskey I brought over with me from the ol' country, and pour it over my grave . . ." Father Callahan, thought for a moment, and asked reverently, "I too have one last favor to ask of you . . ." "What is it?" "I was wondering, if I may not run it through me kidneys first?" (As Tom heard it from **Chuck Leahy.**)

GRAFFITI by Phil Lee

Person who walks on the beach—Santos
Person who sleeps in his car—Cardoza

COMMUNICATION GAP

Between drinks at **Ed Yamada's** open house, **Masaru Koike** told us about his patient from Hong Kong who was discharged with Darvon compound for pain after an uneventful circumcision. . . . The patient returned several days later in terrible agony. Close inspection of the angry surgery site revealed a mysterious fine powder spread carefully into the wound . . . The patient had taken each Darvon capsule apart and with meticulous care spread its contents on the wound every four hours as prescribed, for pain. **Yutaka Yoshida** screws up his face with sympathetic pain when he recalls his own patients' experiences . . . He carefully informs his patients, half jokingly of course, so as not to offend their basic intelligence, to remove the foil covering from their hemorrhoidal suppositories before inserting. . . . **Phil Lee** took the cue from there and told how he was threatened with suit by a lawyer, who when prescribed the routine two Dulcolax suppositories, swallowed whole the fairly large wax covered inserts with considerable agony and choking, and then decided to read the label . . . We, of course, have had several patients who, even after careful instructions, remove the insert heads from the plastic fleet enema containers and drink the contents with gusto before their scheduled BE and procto . . . The patients, while pleased with the laxative effect, find the taste rather repugnant . . .

Sportsmen

Miscellaneous

With the advent of Ping-pong diplomacy, **David Pang** suggests that the annual HMA sporting events include a Ping-pong Tournament as well. He suggests **Cyrus Loo** for chairman and informs us that both **George Nip** and **Tommy Chang** were former champs. More recently, we note that Cyrus bested lawyer **Hyman Greenstein,** who then contributed Ping-pong tables, paddles, nets and balls to Halawa Jail and the Boys Detention Home as he promised. Cyrus also received the following note from Hyman: "When you get a little older and your game starts slipping, call me for a rematch."

We are also in charge of a first, a HMA Skin Diving Tournament, and are looking for participants and possible diving sites, either here or on another island. Thus far, **Tom Frissel, Bill Davis, Ted Tsen,** and **Herb Uemura** have expressed interest . . .

We gleaned from **Ed Sherman's** column that **William Lockward** parachute jumps as a hobby.

Surf Bum: **Malcolm Ing** recently placed 4th in the Senior Men's Division (age 35 and over) of the State Surfing Meet at Ala Moana . . . We wondered what happened to **Fred Gilbert** this year . . .

Duffers: The annual Medical Arts Golf Tournament was held at MidPac CC on Aug. 5 with 80 participants. In the guest flight, **Dick Lam** who had two hole-in-ones last year, shot a sparkling 77-9-68 to win first place. **Ed Kagihara** with a 93-23-70 was 4th and at net 71's were **Tom Fujiwara, Dick Omura, Herb Takaki** and **Vic Mori.** In the Medical Arts flight, **Ed Emura** shot a brilliant 77-11-66 to tie with **Don Maruyama** who recovered enough from his tennis elbow to shoot 80-14-66. Don won the toss and the dubitable privilege of running the tournament next year. . . . In 3rd place was perennial winner **Y. Fukushima** and in 5th place **Ed Izawa.** Other winners included **Hideo Oshiro** in 6th, **Frank Fukunaga** in 7th, **Kiku Kuramoto** in 8th and **Roy Iritani** in 9th. High Gross honors was again won by **Walter Yokoyama.** . . .

A Golfer's Prayer (Thanx to **Heather Akana**)

The Pro is my shepard, I shall not slice,
He maketh me to drive straight, Down green fairways,
He leadeth me softly, Across still water hazards,
He restoreth my approach shots,
He leadeth me in the paths of accuracy, For my game's sake,
Yea, though I chip through the roughs, In the shadow of sand traps,
I fear no bogeys, For his advice is with me,
His putter and irons, they comfort me,
In the presence of my opponents,
He anointed my head with confidence,
The cup will not be runneth over;
Surely birdies and eagles shall follow me
All the rounds of my life,
And I will score in the sixties (maybe low seventies),
Forever and ever.

AMEN

Catalino Cachero's 19th Hole Repertoire:

"Why did the country boy move to the city?" "He got tired of mountin women."

Can a woman make a millionaire out of her husband? Yes, if he was a billionaire to begin with.

A man tells his wife that he has an idea that will save his company thousands of dollars a year . . . "I didn't know," said his wife, "that you were thinking of resigning . . ."

Tutor Oncologists

Through the efforts of **John Keenan** et al of the Cooperative Chemotherapy Program and the funds of the RMP of Hawaii and the American Cancer Society, Hawaii Division, we were blessed with three outstanding "tutor oncologists" **George Santos, Emil Freireich,** and **Emil Frei III.**

First came George Santos from Johns Hopkins in early June. **Quint Uy** who knew George from "the good old days in Baltimore" explained, "Dr. Santos does not come from Kalama Valley." (Referring to the recent fracas another George Santos and his pigs were having with the Bishop Estate over in Kalama) George, a friendly, youthful, mop topped, brilliant speaker kept the audience inspired with his knowledge and enthusiasm. He lectured on immunosuppression, bone marrow transplantation, tumor immunology, immunotherapy chemotherapy of the lymphomas, etc. The lectures were well organized, with ample slides and chock full of information and we took reams and reams of notes for future digestion . . .

Next came Emil Freireich from the M. D. Anderson Hospital and Tumor Institute . . . **Noboru Oishi** described him as a "dynamic, succinct speaker," and he was. Emil, soft spoken, slightly rotund, with curly top, long side burns and occiput tresses was a messiah of optimism. Emil maintains that "understanding makes for clarity." He covered leukemias, platelet physiology, cancer research, supportive therapy in chemotherapy, etc. When showing slides, he insisted that lights be only slightly dimmed. "I find very low lights very soporific and I cannot talk to a sleepy audience." On Aloha Friday, he was bedecked in Aloha shirt and lei and claimed, "I feel like an entertainer." Emil, we felt, was the epitome of the perfect lecturer, interesting, self effacing and tolerant . . .

Herein are a few gleanings . . .

"Leukemia is a disorder that lends itself to study in man . . . The myeloid marrow is easy to quantitate objectively and blood can be studied repeatedly without harm to the host. . . . The ideas and concepts of therapy come from leukemia treatment. . . ."

"Survival in childhood leukemia is approaching 100% from an expectant 95% mortality in the past."

"In acute adult leukemia, the duration of survival is a function of the response . . . The problem is irradication of residual disease . . ."

"With chronic myelocytic leukemia (CML), we haven't the foggiest idea what's wrong with these people . . . CML patients are asymptomatic, but once diagnosed, watch out, for the doctor knows exactly what to do . . . Wih Myeloran therapy, the liver and spleen go down and the WBC's become normal . . . ie there is complete remission, but their immediate lifespan is not prolonged . . . Everyone has demonstrable immunosuppression, and infection becomes a problem only in treated CML patients . . . The patients develop pulmonary fibrosis, sex organ fibrosis, but the myelosuppression is the most serious complication . . ."

"The human nature of man is an obstacle to chemotherapy . . . Since we know Myeloran is so good, doctors are reluctant to do plasmaphoresis . . . Our goal should be to learn if the benign phase is longer with plasmaphoresis . . . Myeloran therapy may be contraindicated."

"Increasingly, man has become aware of creating an environment for his survival . . . In cancer, there is a universal decrease in host resistance . . . Germ free environment is important for high risk patients, especially with leukemia patients . . . 85-95% of the morbidity and mortality is from infection. I am not sure that patients die from leukemia . . . They almost always die of complications, eg infection, hemorrhage, etc."

"Never treat with antibiotics until culture and sensitivity is done . . . There is a real danger of superinfection, particularly with Pseudomonas . . . Fever is the most important sign of infection in leukemia and other myelosuppressed patients . . . The most valuable antibiotic in our Clinic is Carbenicillin . . . There is an over 95% effectiveness with Carbenicillin. . . ."

Re blood component donation: "Anytime a transfusion is indicated, you would do better with the component."

"One of the most significant developments in our culture is the development of technology which extends our perspective such as X-rays, EKG's etc. I feel that

the blood cell separator is such a significant contribution. . . ."

Last came Emil Frei III, associate director of the M. D. Anderson Hospital and Tumor Institute; tall, bandy legged, prematurely alopecic with beady intense eyes and by Gad, positively brilliant. Emil is a blackboard scribbler of hieroglyphics who doesn't believe in slides and is addicted to colorful psychedelic ties. His descriptions are sheer poetry, eg "opportunistic infective agents" for infections occurring in chemotherapy. Emil spoke on endocrine tumors, GI, GU and GYN tumors, cell population kinetics, combination and curative chemotherapy, etc. Herein are a few intelligible quotes:

"Combination therapy is not an island. . . . Juxtaposed with radiotherapy and surgery, it makes good sense. . . ."

Re immunotherapy and chemotherapy: "The two modes are supplemental. . . . Chemotherapy has the greatest potency and immunotherapy has selectivity. . . ."

"Integration of the various disciplines must be available. . . . 'No man is an island' . . . especially with the information explosion. . . ."

Other Visiting Physicians

July also brought immunologist **Benjamin Gordon** from the U. of British Columbia and he spoke on "The ABC's of Immunology." Kuakini Research's **Mitsuo Yokoyama** who is rather diminutive by comparison introduced Benjamin as "The tall husky man who wrote two books on the fundamentals of immunology. . . . First you should buy his books instead of going to the library. . . ." Benjamin says, "There are two ways of presentation, black and white, or shoot for the interminable shades of grey. . . ." He did both, struggling for choice words and laboriously getting his points across. . . .

Conference Humor

A 68 year old Japanese woman was found at surgery to have adenoCA of the sigmoid colon with metastasis. In viewing the preop BE films, radiologist **Carl Boyer** was puzzled: "I can't find the tumor." **Takakazu Fukumura** pointed to an obscure portion of the sigmoid and declared confidently, "It's right here." Carl conceded, "I don't see it, but I certainly can't argue with success. . . ." Moderator **Noboru Oishi:** "While they're looking for the lesion, let's proceed. . . . Quint?" **Quint Uy:** "If you were **Dr. Ansfield,** you would treat this patient with 5 FU. . . ." Noboru wondered, "When do you stop?" **Charles Tashima:** "You treat forever. . . . You don't know when. . . ." Noboru quizzed, "How do you measure?" Quint: "Do a chest X-ray every 3 months and liver function tests." Charles added, "I would go along with chest X-rays and liver scans every 3 months. . . ." **Grant Stemmerman** was aghast, "Liver scans every 3 months?" Noboru mediated, "The more you do, the lower the cost, I suppose."

A 56 year old Japanese woman with metastatic Rt breast Ca was treated since 1967 with a Rt radical, post op irradiation and 5 FU. She is now admitted with hoarseness and a Rt neck mass. **Glenn Kokame:** "She has a left vocal cord paralysis." Internist **Cool Wakai:** "With the recurrent laryngeal nerve on the left and the mass on the right, will some surgeon tell me how she got hoarse?" Radiologist Carl Boyer offered, "Perhaps she doesn't know its on the wrong side."

A 42 year old Portuguese man who was a heavy smoker all his life was admitted with headaches and a 20 lb. weight loss. A brain scan showed a Lt parietal lesion and chest films a Lt hilar mass which on bronchoscopic examination proved to be anaplastic bronchogenic Ca. Radiologist **Ed Quinlan:** "I radiated his chest and also gave him total brain radiation. . . . There has been a great change in affect. . . . He was wild the

continued page 430

Trent
Medical Personnel Bureau
521-2948

LINDA LOUISE TRENT—*Executive Director*

"Serving the Personnel Needs of the Medical Profession"

Integrity — Efficiency — Courtesy

- **HOSPITALS**
- **CLINICS**
- **EXTENDED CARE FACILITIES**
- **CONVALESCENT HOMES**
- **RESTORATIVE DEPT.'s—O.T.S.'s & P.T.'s**
- **MEDICAL AND DENTAL ASSISTANTS**
- **LABORATORY AND X-RAY TECHNICIANS**
- **RNs-LPNs-NURSES AIDES**
- **HOME CARE AIDES AND COMPANIONS**
- **OFFICE PERSONNEL**
- **MEDICAL SECRETARIES**
- **MEDICAL STENOGRAPHERS**
- **MEDICAL AND DENTAL RECEPTIONISTS**
- **MEDICAL RECORDS LIBRARIANS**

Personnel carefully screened, evaluated and references verified.

521-2948

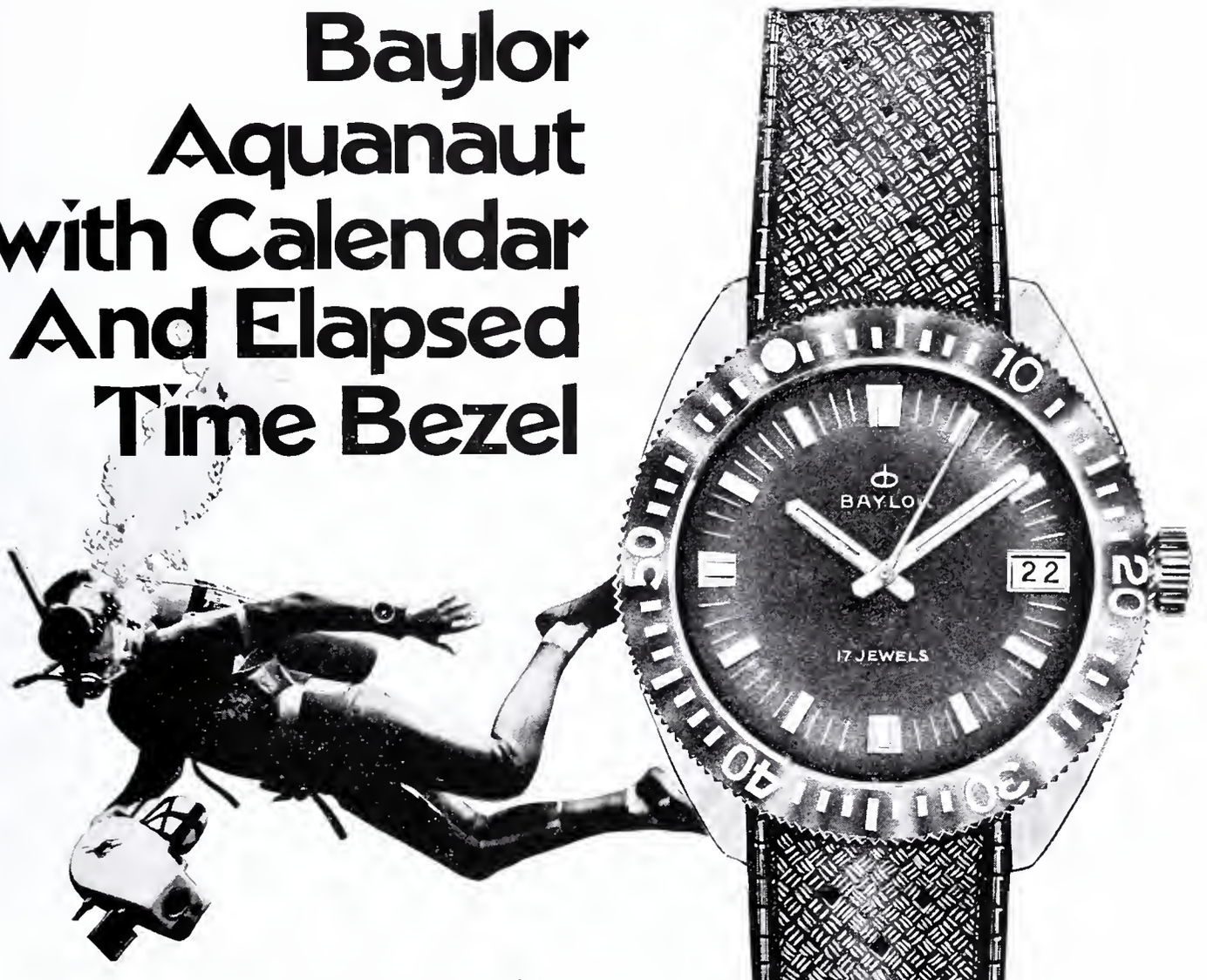
Hawaii Licensed Private Duty
Female and Male
Registered and Practical Nurses

1311 Kapiolani Blvd. — Room 407
Hawaiian Life Insurance Bldg.

Monday thru Friday — 8 A.M. to 5 P.M.
Closed Holidays

Our exclusive 17-jewel sportster,
fantastic for performance, value.

Baylor Aquanaut with Calendar And Elapsed Time Bezel



Water tested up to 600′ for skindivers, swimmers.

Calendar changes date at midnight.

Great timekeeper; easy to read luminous dial.

Stainless case; tropic-tested sportsman's strap.

Zales Custom Charge
Use Your Credit at Zales

Only $25.00

ZALES®
JEWELERS

We're nothing without your love.

DOWNTOWN 1045 BISHOP • KAHALA MALL • KAILUA SHOPPING CENTER • HILO MALL

INSURANCE EXCLUSIVELY

Brainard & Black, Ltd.

1712 S. King Street, Honolulu 96814

Telephone: 949-0031

"Small enough to know you, Large enough to serve you"

first day, but now quite docile. . . . He wants to go back to Maui and I keep telling him, 'Maui No Ka Oi.'"

Professional Moves

We wish to report that *Homo Sapiens Medicus,* aroused from its winter-spring hibernation, is migrating with unprecedented vigor these summer-fall months. In July, tennis playing cardiologist, **Simon Cheng,** settled with the Dickson-Bell Medical Center; GP (a rarity these days) **Harold Machigashira** joined the Windward Medical Center, and psychiatrist **Leonard Jacobs** was assigned to the Diamond Head Mental Health Center. On Hawaii, another GP, **Arthur Sohn** joined **M. L. Chang** of Hilo and psychiatrist **Tore K. Nielsen** was appointed chief of the West Hawaii Mental Health Clinic in Kona.

Medicus continued its flurry of activity into August. Surgeon **J. Brysson Greenwell** and internist **Eugene Matsuyama** joined the Honolulu Medical Group. Pediatric cardiologist **Edgar C. K. Ho,** nephrologist **Eugene G. C. Wong** and psychiatrist **Kosta Stojanovich** joined the Straub Clinic, and yet another GP, **Michael H. Dang** and OB man **Fook Chiu Li** (who trained at Kapiolani) joined the Chock-Pang Clinic. Among the independents, neurologist **Stanford Au** joined **Jordon Popper** at King-McKinley Building; pediatrician **Richard Mitsunaga** joined **Raymond Wong** in Pearl City, and ophthalmologist **Allan Kunimoto** opened his solo practice in the Professional Center Building. **Pat Lai** and **Warren Wong** relocated to the King Center Building. On Maui, internist **William James** joined the Maui Clinic, and on Kauai, psychiatrist **Cort Langerak** became chief of the Kauai Mental Health Services. On Oahu, pediatrician **Mary McKenzie-Pollock** became clinical director of the Children and Youth Project in Waimanalo. On Hawaii, internist-cardiologist-adventurer **Herman V. Platt** and pediatrician **Ruth Matsuura** joined the Hilo Medical Group Inc.

Going into September, radiologist **Sidney Wong** and OB man **Philip McNamee** joined the Straub Clinic. Pediatrician **Fernando Atienza** joined the Fronk Clinic and surgeon **Ignacio Torres** joined the Phil-Am Medical Associates Inc. at 1300 Pali Hwy. We are also happy to announce that former Tripler troubadour Maj. **Edwin Dierdorff** who entertained us at the annual HMA banquet; the Kuakini staff party, and other functions has doffed his uniform and opened his office at the Kailua Professional Center Building specializing in ENT (and perhaps folk singing as well?).

We also wish to apologize to faithful reader and Eye man **Malcolm Ing** for missing the announcement of his move from the Ala Moana Building to the Pan Am Building back in April. It seems that he is still getting mail and calls at his old office.

Elected, Appointed, and Honored

On the academic front, in July, **Thomas Cashman** was elected a Fellow in the American Academy of Pediatrics. Also in July, we learned that **James Ball, Melvin Levin, James Lumeng** and **Howard Keller** (MC) of Honolulu and **Peter Kim** of Kauai were




BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks. brown & white patches, broken veins, tattoos. burns. scars. on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary

OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288

ZIMMER
MEDICAL INDUSTRIES, LTD.
MILTEX

ORTHOPEDIC EQUIPMENT & SURGICAL INSTRUMENT SPECIALISTS

Don Bloedon
John McCready

Phone 949-0396
949 McCully Street, Room 11
Honolulu, HI 96814

granted fellowships in the American College of Physicians. In August, **Jim Orbison,** ACC Governor of Hawaii listed **Bernard Yim** as a new Fellow in the American College of Cardiology. The American College of Physicians also announced that **Bertram Weeks** of Maui completed its post graduate course in internal medicine.

On the religious front, **James Fleming** was elected moderator of Wailuku Union Church. On other fronts, we note that **Sau Ki Wong** is president of the newly formed Hawaii Association for Eye Safety and **Tom Maeda, Jr.** is auditor. The organization hopes to make the public eye-safety conscious. **Herbert Nam,** past president of the Korean Chamber of Commerce, was one of four Hawaii residents of Korean ancestry who left for a good will mission to Korea.

We also wish to set the record straight regarding **George Mills'** recent appointment to the newly formed Institute of Medicine of the National Academy of Science. George was appointed for a five year term and he will serve with the 20 member Medical Sciences Division of the Institute. The Institute, incidentally, has only 110 members nationwide.

Entrepreneurs

Physicians do have varying interests, although at first glance it would seem that they are only concerned with golf, tennis or fishing. Hilo's **Timothy David Woo** breeds horses, a hobby which he developed with a passion when he practiced at Parker Ranch 30 years ago. Timothy breeds palomino horses, but recently he has successfully reproduced four stallions and three mares of the "Kanaka Horse," a descendant of the Spanish Mustang. The Spanish Mustang was the first horse brought to the Islands in 1804 and became near extinct by inbreeding with other strains. Another horse fancier, **Edwin Willett** of Lanai, owns *Mr. Sam* who recently won the 5/8 mile race for thoroughbreds at the Fairgrounds on Maui.

Chisato Hayashi of Kona is president of a non-profit project to establish a $1.5 million home for the elderly in Kona. The committee is asking the Bishop Estate for a lease on a prime parcel of Keauhou land at a cost of $1 a year for 99 years. The Honolulu Medical Group will start construction of a seven-story $6.9 million clinic at Beretania and Lauhala near Queen's Medical Center. The clinic is scheduled for completion in early 1973 and will have general and plastic surgery operating rooms, a complete pharmacy and a clinical pathology laboratory.

It seems that Hana, Maui is suffering from its worst drought in 50 years and **Milton Howell** is trying to persuade a reluctant County Board of Water Supply and the Mayor's office to hire a rain maker to seed the clouds. . . .

Hors De Combat

Emergency calls can indeed be an emergency as **Alfred Burden** of Maui has learned. In June while responding to such a call, his 1968 model foreign car exploded and the entire rear portion was damaged to the tune of $2.000. . . . In July, **E. Gordon Dickie's** office was

WILLIAMS MORTUARY
"CHAPEL OF THE CHIMES"
1076 S. Beretania St., Phone 537-2587
Ample Parking Adjoining Mortuary
OVER A CENTURY OF SERVICE
"Service measured not by gold but by the Golden Rule"
MEMBER
National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

broken in and drugs and pep pills stolen. The police apprehended the burglar.

An indictment against **James Shinn** for knowingly refusing to keep a record of incoming and outgoing drugs was dismissed by the federal judge when the attorney argued that the indictment was faulty because it included alleged violations both prior to and after the new record-keeping law became effective. The government will seek a new indictment.

Howard Liljestrand, vocal spokesman for The Citizens Against Noise Committee, describes "the helicopter as the worst noise producer in the City." Howard's group asked the Police Department to abandon the use of its helicopter, but Chief Keala indicates that rather than ground the present copter, the department plans to buy yet another noisy chopper. . . .

In the wake of the tragic burn death of a prominent Islander in a hospital bed fire at Queens, a survey of the smoking and fire prevention policies of 12 major hospitals showed that most do not have strict prohibitions against smoking because they feel that such rules will not be followed by patients anyway; that most have fire retarding draperies and rugs, but no fire-resistant clothing, bedsheets or blankets; that all have comprehensive fire insurance which would cover any fire caused by the carelessness of a patient, and that no other hospital, in recent memory, has had a fire started by a smoking patient.

The inmates of Halawa Jail filed suit against the Mayor and the City Physician for "the denial or limitation of medical services necessary to maintain their well-being and life." It seems that a 28 year old woman who shot her 33 year old boy friend to death had to smuggle her asthma pills into jail, another woman inmate suffering from GC was refused her medication, an inmate with stomach pains was not satisfied with stomach mints, and a known narcotics addict was described as a malingerer. . . . Tsk . . . Tsk. . . .

Richard D. Zandee van Rilland's medical staff privileges at Molokai General Hospital were restored after a 3 year suspension, thus over-ruling the recommendations of his three medical associates. Poor Richard says rather tragically, "To stay alive, I've had to perform (as pianist, organist, and tenor saxophonist) at nightclubs and even worked as a $1.60 guard for the Burns Security Agency from November 1969 to March 1970."

Mrs. Jones, a Waianae housewife started to have some postpartum bleeding. The single Waianae ambulance was out on a call so a helicopter pilot flew her to Kaiser Hospital instead of St. Francis Hospital because the heliport was closer. Now, Kaiser doesn't have an ambulance, so when a City and County ambulance was suggested for the transfer to St. Francis, the impatient pilot took off again and landed near Queen's Medical Center. With police assistance, they rushed Mrs. Jones into the emergency unit where she was admitted at 1:45 p.m., examined, and promptly discharged 15 minutes later at 2 p.m. The pilot said ruefully, "It looked like an emergency to us." (All smoke and no fire eh?)

We were indeed happy to read in an inspiring Letter to the Editor from a **Donna A. Spaulding** that her roommate, **Dr. Grummert,** the only physician in Hawaii Kai, does make house calls or meets her patients in her office above the Bank of Hawaii in the Hawaii Kai Shopping Center and has never refused to treat a patient because of the hour of night. She states that Dr. Grummert also has full emergency equipment in her office for cases which may require resuscitation, electrocardiogram diagnosis, etc. It appears that all her equipment is portable which enables her to better serve the families in Hawaii Kai. . . .

continued page 434

OXYGEN AIR-CONDITIONED

24-HOUR SERVICE

Physician's



531-0477

AMBULANCE SERVICE, INC.

Hawaii's Finest

Carnation
EVAPORATED MILK

HAWAII'S HEALTHY BABY MILK...



1970
Carnation Healthy Baby Contest
$1,000 1st prize winner,
David Culver Holbrook
of Honolulu, Hawaii



1st CHOICE FOR INFANT FEEDING...
No. 1 in the Islands for generations,
...available everywhere in Hawaii

"from Contented Cows"

Announcements

CALL FOR ABSTRACTS

The Regional Meeting of the American College of Physicians will hold its annual meeting February 22-23, 1972 in Honolulu.

Contributions to the Scientific Program are solicited. Special consideration will be given to papers from students in the field of health sciences, house officers, and Members of the College. Abstracts (250 words or less) should be submitted by **November 1, 1971** to: K. D. Gardner, Jr., M.D., F.A.C.P., Chairman, Scientific Program Committee, Hawaii Region, American College of Physicians, 3675 Kilauea Ave., Honolulu, Hawaii 96816.

POSTGRADUTE COURSE: RESPIRATORY PATHOPHYSIOLOGY

November 1-5, 1971, Royal Victoria Hospital, Montreal, Que., Can. This course is designed to bridge the gap between respiratory physiology and clinical pulmonary medicine. Information and application: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

POSTGRADUATE COURSE: CURRENT CONCEPTS OF CLINICAL INFECTIOUS DISEASES

November 3-5, 1971, University of Virginia Medical School and Boar's Head Inn Conference Center, Charlottsville, Va. This course will be devoted to the management of common infectious problems and to an appraisal of advances in the field of infectious disease and immunology. Information and application: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

GRANTS FOR SCIENTIFIC RESEARCH IN LEUKEMIA

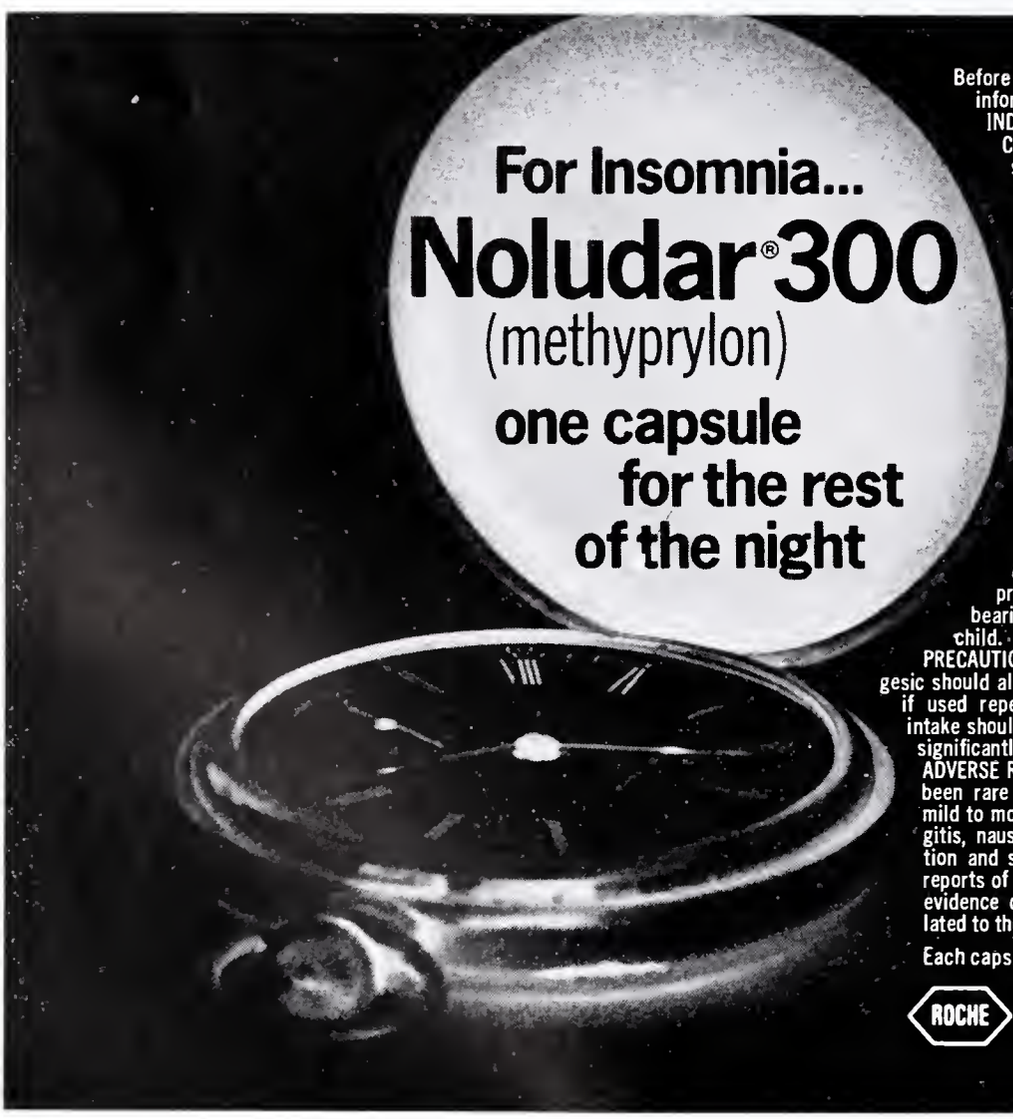
Applications for grants are now being accepted by the Leukemia Society of America, Inc. Applications must be submitted before November 1, 1971 for review in late January. Approved grants will commence July 1, 1972. Applications may be obtained by writing the Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 East 43rd Street, New York, N.Y. 10017.

AMERICAN COLLEGE OF NUTRITION TO HOLD SESSION IN NEW ORLEANS

The 12th Annual Session will be held November 28, 1971 at the Royal Sonesta Hotel, New Orleans, Louisiana. Clinical research reports on the role of nutrition in manned space flights, on diabetes, on anemias and on gastrointestinal disorders will highlight the program. Symposiums on hyperlipidemia and atherosclerosis will also be held. For more information write: A. Leonard Luhby, M.D., Secretary-Treasurer, American College of Nutrition, 1240 Fifth Avenue, New York, N.Y. 10029.

FIFTH ANNUAL POSTGRADUATE CONFERENCE TODAY'S HOSPITAL PROBLEMS: AN INTERDISCIPLINARY APPROACH

November 10-13, Tides Hotel and Bath Club, Redington Beach, Fla. This conference is specifically designed for Chiefs of Staff, Hospital Administrators and Governing Personnel (or Trustees). Information and application: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.



Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

AMERICAN ACADEMY OF DERMATOLOGY 30TH ANNUAL MEETING

December 4-9, 1971, the Palmer House, Chicago, Ill. The Academy plans to have two days of in-depth post-graduate courses followed by four days of general scientific sessions, symposia, seminars-in-depth and small group discussions. Information: Frederick F. J. Kingery, M.D., Secretary-Treasurer, 2250 Northwest Flanders St., Portland, Ore. 97210.

CONTINUING MEDICAL EDUCATION PROGRAM

The program entitled "Coronary Artery Disease and Cardiac Arrhythmias" will be held on November 19, 20 and 21, 1971 at the Surfrider Hotel, Honolulu. Co-sponsors: The American College of Cardiology in co-operation with the University of Hawaii School of Medicine. For further information, write: Miss Mary Anne McInerny, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

TWELFTH CONGRESS OF THE PAN-PACIFIC SURGICAL ASSOCIATION

February 26 to March 4, 1972,* Hilton Hawaiian Village Hotel, Honolulu. Concurrent meetings will be held in: Anesthesiology, Colon & Anorectal Surgery, General Surgery, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-Cardiovascular, and Urology. For details write: Cesar B. DeJesus, M.D., Pan-Pacific Surgical Association, 236 Alexander Young Bldg., Honolulu, HI 96813.

* Please note change in date from March 3 to March 4, 1972.

MED SEC SERVICES

Complete Secretarial Service
Including Specialist for
Medical & Legal Professions

IBM DICTATION EQUIPMENT
24 HOUR SERVICE

DIRECT LINE DICTATION

- Medical Insurance Reports
- Surgical Reports
- Progress Notes
- Pathology Reports
- Consultation Reports
- Manuscripts
- Resumes and Miscellaneous
- Histories & Physicals

MED SEC
SERVICES

531-3577

SUITE 617 — 1270 QUEEN EMMA

For *World* *Travelers*

WHO HAVE BEEN EVERY-WHERE



HAWAII CONDOMINIUM RENTALS: Enjoy a quiet week or month of just plain beauty, swimming and hiking in tropical Hawaii. Just 7 miles beyond the Princeville Golf Course (less than that for deep sea fishing!). HANALEI COLONY RESORT on the North Shore of Kauai, Hawaii's Garden Island. Nestled in giant Australian pines, right on the pounding surf of the Pacific. No night life; just the tropical moon. Two large bedrooms accommodate 4. Complete kitchen with refrigerator, washer/dryer. Daily rates for 2 from $26. Weekly and monthly rates also are available.

For a week or month of beautiful quiet, tropical living, write:

Hanalei Colony Resort

For reservations call collect
Kauai 826-6235

COMBINED REGIONAL TUMOR CONFERENCE SCHEDULE

1971-72

Friday, November 5, 1971—12:30 p.m.
Kapiolani Hospital
Management of recurrent, advanced and refractory gynecologic malignancy

Monday, December 13, 1971—4:30 p.m.
Queen's Medical Center
Soft Tissue Sarcoma

Friday, January 8, 1972—7:15 a.m.
St. Francis Hospital
Carcinoma of the Biliary Tract

Monday, February 14, 1972—1:00 p.m.
Kuakini Hospital
Carcinoma of the Gastrointestinal Tract

Monday, March 6, 1972—4:30 p.m.
Queen's Medical Center
The management of central nervous system compression due to malignant disease

Friday, April 14, 1972—8:00 a.m.
Kaiser Hospital
Tumor conference—selected case presentations

Tuesday, May 16, 1972—12:30 p.m.
Children's Hospital
The management of childhood lymphoma

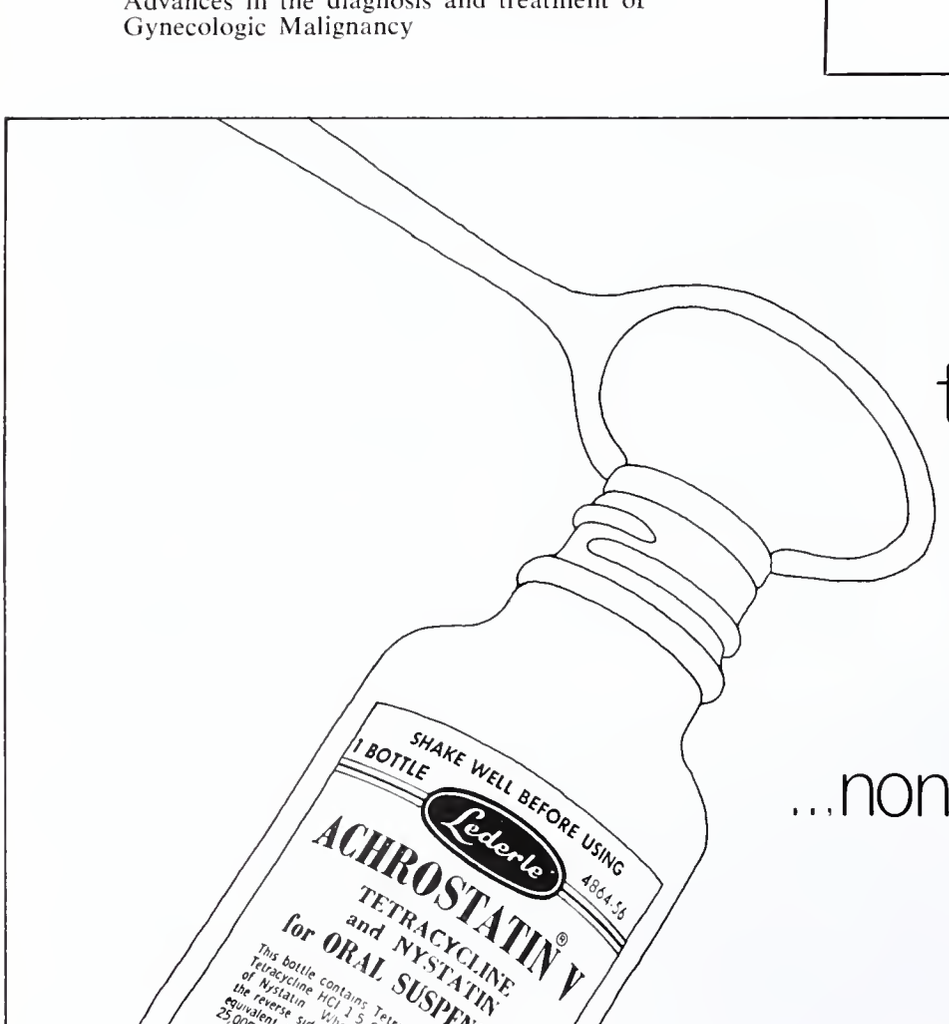
Friday, June 2, 1972—12:30 p.m.
Kapiolani Hospital
Advances in the diagnosis and treatment of Gynecologic Malignancy

Dial 537-5353

for the finest printing service in the state

star-bulletin printing company

420 WARD AVENUE HONOLULU, HAWAII 96814



of the tetracycline-nystatin products

...none is lower priced

TETRACYCLINE HCl 25 mg. NYSTATIN 25,000 U./cc.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

Our "Angels"

PAGE

Amfac Distribution Company
Drug Department 425

Arch Laboratories
Dicarbosil 424

Bishop Computer Center..... 374

Brainard & Black, Ltd..... 430

Burroughs Wellcome & Co. (USA), Inc.
Empirin Compound 441
Neosporin 376

Campbell Soup Company
Soup 401

Carnation Company 433

Coca-Cola Bottling Company of Honolulu, Inc..... 381

Hawaii Medical Service Association..... 380

La Pietra Development Corporation..... 423

Lederle Laboratories
Achrostatin V 436

Lilly, Eli, & Co.
V-Cillin K 382

Mead Johnson Laboratories
Prosobee 377

Medical Industries, Ltd..... 431

Medical Placement Bureau..... 381

Med Sec Services..... 435

National Drug Company
Tepanil/Quinamm.....Insert (between 376 & 377)

PAGE

Newton, C. R., Co., Ltd..... 418

O'Leary, Lydia, of Hawaii
Covermark 430

Optical Dispensers of Hawaii, Inc..... 381

Physician's Ambulance Service, Inc..... 432

Robins, A. H., Co., Inc.
Robinul 438, 439
Donnatal/Allbee.....Insert (between 380 & 381)

Roche Laboratories
Efudex 370, 371
Librax 442, 443
Valium 448
Noludar 434
Noludar 440

Searle, G. D., & Co.
Ovulen/Demulen 446, 447

Shirley Olds 435

Smith Kline & French Laboratories
Dyazide 444

Stanford University Medical Center..... 445

Star-Bulletin Printing Company..... 436

Trent Medical Personnel Bureau..... 428

Upjohn Company, The
E-Mycin 372

USV Pharmaceutical Corp..... 378, 379

Waimea Village Inn..... 440

Williams Mortuary 431

Zales Jewelers 429

gastritis



when G-I symptoms demand a potent synthetic anticholinergic

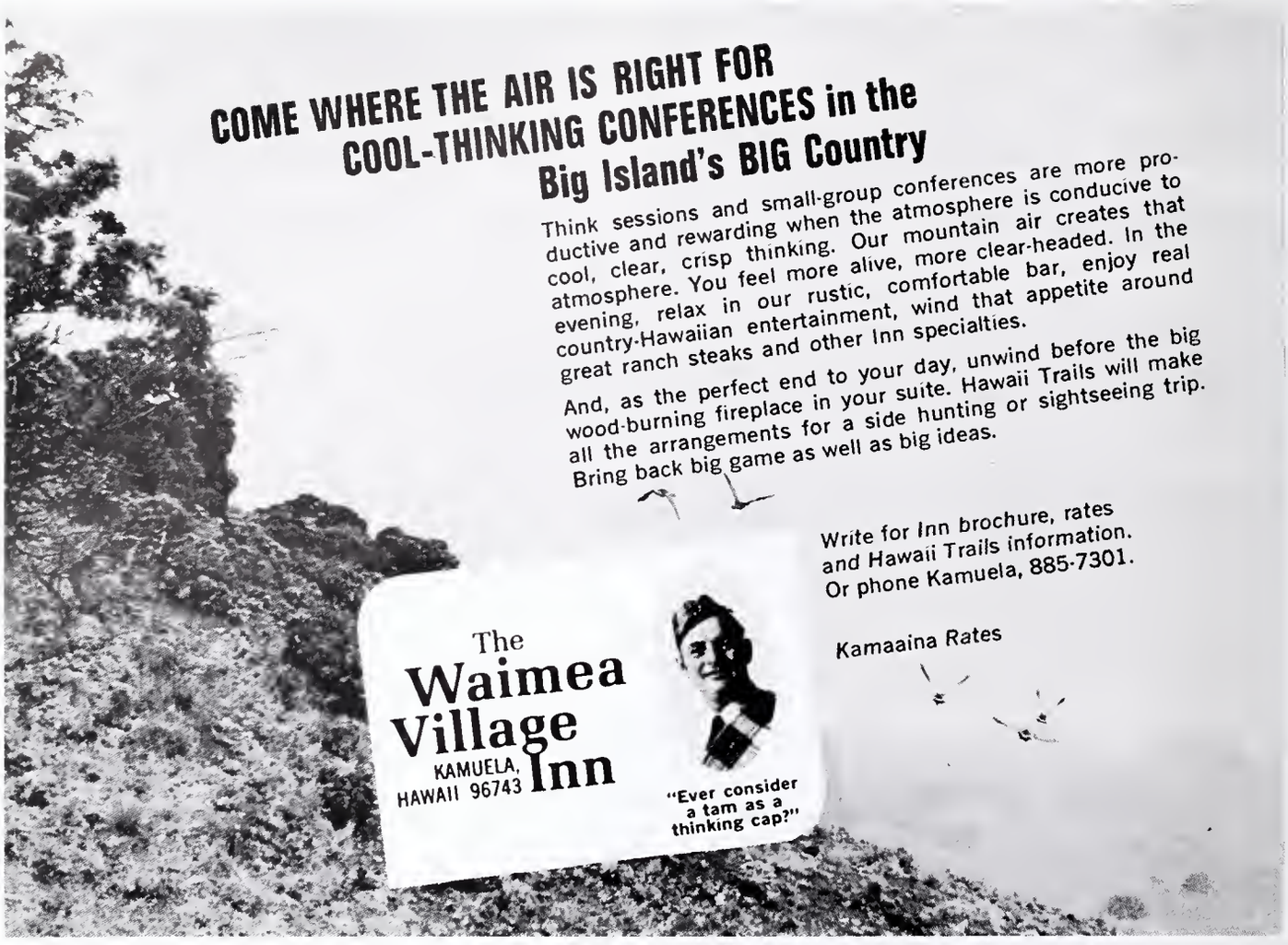
move up to "the Robinul response"

In treating hypersecretion and hypermotility associated with gastritis are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent anticholinergic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of gastric hypersecretion, making it a highly effective agent in gastritis and other upper G-I conditions associated with hypersecretion and hypermotility. Because Robinul Forte exerts a profound antispasmodic action, it is also useful in the treatment of lower G-I disorders, such as functional bowel distress and spastic and irritable colon. If the patient has a "one tract mind" concerning his condition, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

Robinul® 2 mg. Forte (glycopyrrolate)

■ INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ CONTRAINDICATIONS Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ PRECAUTIONS Administer with caution in the presence of incipient glaucoma. ■ SIDE EFFECTS The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ DOSAGE The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ SUPPLY Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. A·H·ROBINS



For Insomnia... one capsule for the rest of the night

NOLUDAR® 300 (methyprylon)



Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Empirin® Compound with Codeine, gr. ½ or gr. 1

Helps overpower pain

Each tablet contains: aspirin gr. 3½,
phenacetin gr. 2½, caffeine gr. ½.
No. 3 contains codeine phosphate* (32.4 mg.) gr. ½.
No. 4 contains codeine phosphate* (64.8 mg.) gr. 1.
*(Warning—may be habit forming.)

CIII Empirin Compound with Codeine is now classified in Schedule III. Available on oral prescription and may be refilled 5 times within 6 months, unless restricted by State law.

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

An intestinal autobiography of rage, contentment and horror*

"Feeling unfairly taxed by the government (Internal Revenue Service) and not given enough attention by A.U.O. [an experimenter to whom the subject became very attached], he became overtly critical and accusatory. He shouted, raged, and threatened to quit."*



"The motility that day was quiet. This type of recording is seen regularly when he is relaxed and contented and the laboratory seems peaceful."*



He was overwhelmed by "paralyzing horror" when told he would need a partial laryngectomy for removal of an early carcinoma; "...the activity of the ileum virtually ceased for over a five-minute period...."*



Background

*Data presented here derive from a 13-year ongoing study by Henry Harrison Sadler, M.D., and Aline Underhill Orten, Ph.D., at Wayne State University. Their findings, which demonstrate a correlation between the emotional state of a human subject and the motility of an isolated segment of his ileum, were published in the April, 1968, *American Journal of Psychiatry*, volume 124, page 1375.

The subject is a 56-year-old man with a 40-cr Thiry loop of ileum created as a result of emergency surgery. A person of modest attainment and simple tastes, the subject depends on the investigators as he might his own family. His full-time job is as a "human laboratory," and throughout the 13-year perio of the study, he has taken great personal pric in his own participation.

A story charged with emotion

The graphs on the facing page are intestinal motility readings on a human subject experiencing the emotions of rage, contentment and horror (see "Background" below left). This "intestinal autobiography" dramatizes the point that certain emotions correlate with specific patterns of G.I. motility.

The visceral clutch and functional G.I. disorders

The gut response to stress has been amply demonstrated in many functional G.I. disorders. Nervous diarrhea and irritable colon syndrome, for example, are disorders associated with abnormal G.I. motility. And these disorders are commonest among patients sensitive to life-stress situations productive of conflict and excessive anxiety.

Librax® calms anxiety, calms the gut

In these areas of G.I. pathology, Librax has become a mainstay of adjunctive therapy. Reason? Effective two-way calming action. Librax, by relieving excessive anxiety, not only helps calm emotional overreaction to stress, it controls intestinal hypermotility, too. Depend on Librax—the only drug that combines the well-known antianxiety action of Librium® (chlordiazepoxide HCl) and the potent, dependable antisecretory/antispasmodic action of Quarzan® (clidinium Br).

1 or 2 capsules, 3 or 4 times daily in the treatment of nervous diarrhea and irritable colon syndrome

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

In functional G.I. disorders, adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

calms anxiety, calms the G.I. tract

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories

STANFORD UNIVERSITY SCHOOL OF MEDICINE

OFFICE OF POSTGRADUATE MEDICAL EDUCATION

announces an interdepartmental course on

INTENSIVE CARE

November 1 - 5, 1971

at the

STANFORD MEDICAL CENTER

This course, including lectures and practical demonstrations, is designed to review in detail the practical aspects of the management of the critically ill patient. Subjects to be covered include:

Resuscitation; shock; monitoring; arrhythmias; vein bypass for impending myocardial infarction; hypertensive crises; surgical treatment of the complications of myocardial infarction.

Thromboembolism; applied pulmonary physiology; respiratory failure; mechanical ventilators; intractable asthma.

Acute renal failure; diabetic ketoacidosis and hyperosmolar coma; lactic acidosis; adrenal crisis; hyper- and hypokalemia; hyper- and hypocalcemia.

Mechanisms of hemostasis; laboratory tests of coagulation; replacement and component therapy; congenital and acquired coagulation disorders; platelet disorders; defibrination and fibrinolysis; acute hemolyses; transfusion reactions.

Gram-negative sepsis; meningitis; upper gastrointestinal hemorrhage; drug ingestion; cerebral death; management of the cerebrally-dead donor.

The course will be presented by the following members of the faculty of the School of Medicine:

Edwin Alderman, M.D.
Roy B. Cohn, M.D.
William P. Creger, M.D.
Frederic L. Eldridge, M.D.
Grant Fletcher, M.D.
Robert H. Goldman, M.D.
Peter L. Greenberg, M.D.
Peter B. Gregory, M.D.
Randall B. Griepp, M.D.
John W. Hanbery, M.D.
Donald C. Harrison, M.D.
Laurence H. Kedes, M.D.
Jack Lazerson, M.D.
Glen A. Lillington, M.D.
John A. Luetscher, M.D.
Roy H. Maffly, M.D.
Thomas C. Merigan, M.D.
Mark G. Perlroth, M.D.
Judith G. Pool, Ph.D.
Richard L. Popp, M.D.
Gerald M. Reaven, M.D.
Eugene D. Robin, M.D.
Edward Rubenstein, M.D.
Stanley L. Schrier, M.D.
John S. Schroeder, M.D.
Alfred P. Spivack, M.D.
Norman E. Shumway, M.D.
James Theodore, M.D.
Kenneth L. Vosti, M.D.

APPLICATION FORM

INTENSIVE CARE — November 1 - 5, 1971

Fee: $200

NAME_____
Last First Middle

ADDRESS_____
Street City State Zip Code

MEDICAL SCHOOL_____ Degree_____ Year_____

TYPE OF PRACTICE_____

Please make your check payable to STANFORD UNIVERSITY SCHOOL OF MEDICINE and mail to the Office of Postgraduate Medical Education, Stanford University School of Medicine, M-121, Stanford, California 94305.

Attendance Limited — Advance Registration Required.

An excerpt from the Searle series "The Ecology of Birth Control"*



The Unwanted Child & Birth Control

Ten thousand battered children—a growing medical problem?

In his daily practice the physician witnesses the human suffering caused by uncontrolled fertility. Perhaps one of its most tragic effects is the unwanted child, who so often experiences parental rejection. The rejected child in a family may be neglected, nagged and severely punished. Sometimes he is criminally abused. Child abuse is common enough to have become a separate clinical entity: the "battered child" syndrome. Reliable statistics are difficult to obtain, but it has been estimated that in this country alone roughly 10,000 children are "battered" per year, and their number may be increasing.

A revealing picture of child abuse patterns is provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

***For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcoming issues will be the history of birth control, the influence of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
FEB 4 1972

NOVEMBER / DECEMBER 1971

HAWAII MEDICAL JOURNAL

VOLUME 30 / NUMBER 6



This is a "sleep cripple"

The geriatric insomniac



Profile of insomnia

Wide-eyed in the darkness, he feels the sense of loss, the loneliness and helplessness that can so often threaten the aged.

Beset by vague aches and pains, fearful of disability, sleep evades him and the night seems endless. Added to his other problems... he has become a "sleep cripple."

The stress resulting from insomnia in the geriatric patient can increase the difficulties of the elderly, and intensify somatic complaints. Allowed to continue, such insomnia may even help prompt the appearance of new symptoms.

When insomnia adds a new dimension to geriatric problems, Noludar 300 can be an effective countermeasure, whether sleep is delayed in onset, broken, or marred by early awakening. A nonbarbiturate, Noludar 300 usually works within 45 minutes, inducing sleep that can last 5 to 8 hours. Paradoxical excitation is rare—an important advantage in the geriatric patient. Drug "hang-over" or morning-after grogginess is generally avoided. Supplied in 300-mg capsules; also available in 200-mg and 50-mg tablets.

Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Noludar® 300

(methyprylon)

one capsule for the rest of the night

ROCHE

ROCHE LABORATORIES
Division of Hoffmann La Roche Inc.
Nutley New Jersey 07110

Upjohn again reduces the price of E-Mycin®



Once again Upjohn has been able to reduce the price of erythromycin without reducing the quality you expect from an Upjohn product.

Upjohn

E-Mycin®

(erythromycin, Upjohn)

Available in 250 mg tablets

THE UPJOHN COMPANY
KALAMAZOO, MICHIGAN 49001

© 1971 The Upjohn Compar
JA71-17

HAWAII MEDICAL JOURNAL

VOLUME 30, NUMBER 6

NOVEMBER-DECEMBER, 1971

$6.00 A YEAR • $1.00 A COPY

Advertising Representative
LILITH JURRY
Phone 946-0053

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1971, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

Published Bi-Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Associate Editor, MERYL H. HABER, M.D.
Contributing Editor, ROBERT H. MOSER, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

The Hawaii Medical Association

Officers 1971

President • HERBERT Y. H. CHINN, *Honolulu*
President-Elect • WILLIAM E. IACONETTI, *Maui*
Past President • JOHN J. LOWREY, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • THOMAS P. FRISSELL, *Honolulu*

County Presidents

Hawaii County • VERNE ADAMS, *Pahala*
Honolulu County • THOMAS P. FRISSELL, *Honolulu*
Kauai County • CHARLES CUSTER, *Waimea*
Maui County • J. MARK B. SOWERS, *Wailuku*
Delegate to AMA • GEORGE H. MILLS, *Honolulu*
Alt. Delegate to AMA • THEODORE T. TOMITA, *Honolulu*

Councillors 1971

Maui • SAKAE UEHARA
Honolulu • GROVER H. BATTEN
Honolulu • WILLIAM W. L. DANG
Honolulu • H. WILLIAM GOEBERT, JR.
Hawaii • ED B. HELMS
Kauai • PETER KIM

Officers—County Societies—1971

HAWAII		HONOLULU
VERNE ADAMS •	President	• THOMAS FRISSELL
DEWITT H. SMITH •	Vice President	• WINFRED LEE
EDWARD BALLERINI •	Secretary	• WILLIAM DANG
ALLAN TAKASE •	Treasurer	• WILLIAM F. MOORE, JR.
MAUI		**KAUAI**
J. MARK B. SOWERS •	President	• CHARLES CUSTER
DENIS FU •	Vice President	• KATOK CHUANG
JOHN WITHERS •	{Secretary} {Treasurer}	• ROBERT BERRY

For Her Future... A Living Trust Now...

She's growing up fast. Before you know it, it'll be time for college.
A good education is important — and you want to make sure she gets the best.
Securities and other assets set aside now in a living trust can be managed in a knowledgeable, impartial manner that will insure the income to see her through college, and later provide that "extra" financial help young families need. Start a trust for *her* future now — see us today . . .

BISHOP TRUST CO., LTD.

Bishop and King • Phone 536-3771
Honolulu, Hawaii 96813



HAWAII MEDICAL JOURNAL

Contents

Volume 30, No. 6 • November-December, 1971

Articles

Multiple Sclerosis: Autoimmune Disease 464
Allan Chinen, and Mitsuo Yokoyama, M.D.

Performance Specifications of an HMO 472
Mrs. H. H. Chun, R.N.

The Activated Coagulation Time Test as a Control for Heparin Therapy 474
Patricia Cho, Frank Bonilla-Linero and Evelyn Yim

Addict Detoxification in a Community Hospital 478
George W. Starbuck, M.D., John J. Hergenhan, B.S., and Mary C. Halloran, M.S.

Editorials

Straub Clinic, Inc. Fiftieth Anniversary Year 484

Features

Annual Index Inserted between pages 500 and 501

Book Reviews 491

County Society News 494

Hawaii Academy of General Practice 489

Inside HMA 488

Letters 462

New Members 496

Notes and News 492

President's Page 486

Slants and Angles 487

X-ray View Box 490

Hawaii Pharmacists' Bulletin

Plaudits 498

Cover: From the collection of Meryl H. Haber, M.D. An original lithograph entitled "The Dream" by Henri Daumier.

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

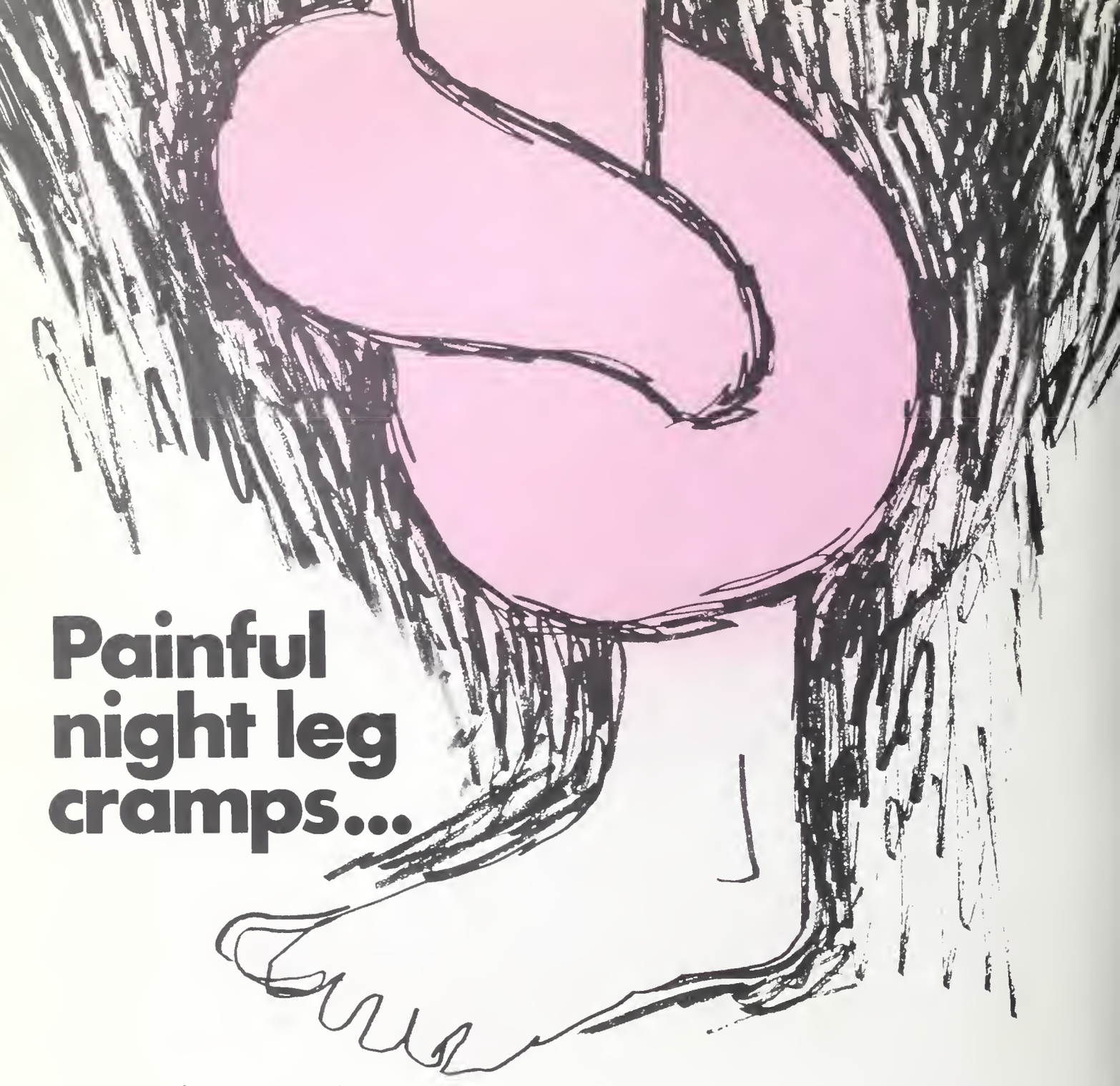
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

1-3326 (2877)

Quinamm™ Specific therapy for night leg cramps

(quinine sulfate 260 mg., aminophylline 195 mg.)



the name dropper

Name dropping is the practice of identifying with greatness. How many of these great names can you drop?
(Answers are in column at left.)

One name you'll have no trouble with is Neo-Synephrine. For ENT examinations, Neo-Synephrine 1% drops have been so dependable for so long—over 30 years—that they are synonymous with "nasal decongestant."

With Neo-Synephrine, nasal passages open quickly for examination and initial therapy. Then, for continued effective treatment at home, the many available dosage forms and strengths of Neo-Synephrine allow you to choose medication specifically for congestion of all stages, for noses of all ages. So well tolerated by delicate respiratory tissue, Neo-Synephrine is recommended even for infants (⅛%) and children (¼%).

Top Row: (l. to r.)
Andrew Jackson
Ulysses S. Grant
Joseph Lister
Sitting Bull
Middle Row: (l. to r.)
Carrie Nation
Benjamin Disraeli
Catherine the Great
Rembrandt
Bottom Row: (l. to r.)
Susan B. Anthony
Booker T. Washington
The Name Dropper
George Washington

Neo-Synephrine® HCl

brand of phenylephrine HCl, USP

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (1475M)

ESTROGEN DEFICIENT WOMAN:



You see her from 45 to 55 with

hot flushes
night sweats
fatigue
headache
palpitations
emotional distress

TREAT HER WITH PREMARIN (Conjugated Estrogens, U.S.P.). PREMARIN offers specific, effective replacement therapy for relief of menopausal symptoms—both physical and emotional—due to estrogen deficiency. It usually provides a "sense of well-being"... helps many patients maintain a more positive outlook.

KEEP HER ON PREMARIN (Conjugated Estrogens, U.S.P.). Continued use of PREMARIN after menopausal symptoms have abated can help protect against further degenerative changes related to estrogen deficiency—changes that often begin in the reproductive organs and extend rapidly to body tissues and skeleton.

REPLACEMENT THERAPY AT ANY STAGE. The estrogen deficient woman can benefit from long term replacement therapy with PREMARIN *at any stage*—whether she is 45 and suffering symptoms of the menopause... a grandmother of 60 with atrophic vaginal tissue... or an even more elderly patient with osteoporosis. PREMARIN therapy is remarkably well tolerated, and relatively inexpensive.

BRIEF SUMMARY

PREMARIN® (Conjugated Estrogens, U.S.P.).

Indication: PREMARIN is specific for replacement therapy of the estrogen deficiency state characteristic of the menopause and the postmenopause.

Caution: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

Suggested Usual Dosage: Menopausal and postmenopausal estrogen deficiency—PREMARIN: 1.25 mg. to 3.75 mg. daily, depending on severity of symptoms. Dosage should be tailored to individual needs of patient. Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

Note: If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. Continue this individualized dosage in subsequent cyclic regimen. *Failure to control bleeding or unexpected recurrence is an indication for curettage.*

Atrophic vaginitis, pruritus vulvae: Cyclically, 1.25 mg. to 3.75 mg. or more is given, depending on tissue response of individual patient.

Available in 4 potencies: *Tablets*—No. 865—2.5 mg. (purple); No. 866—1.25 mg. (yellow); No. 867—0.625 mg. (red); and No. 868—0.3 mg. (green). In bottles of 100 and 1,000.

AYERST LABORATORIES
New York, N.Y. 10017

Ayerst®

7053

therapy for all stages of estrogen deficiency

NATURAL ESTROGEN THERAPY

PREMARIN®

BRAND OF

CONJUGATED ESTROGENS, U.S.P.

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories



the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, anger, and frustration. It's very likely that these psychic factors actually accentuated his perception of pain. Surely the last thing he needs is an analgesic containing caffeine. A much more logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. *Contraindications:* Hypersensitivity to any of the components. *Precautions:* As with all phenacetin-containing products, excessive or prolonged use should be avoided. *Side effects:* Side effects are uncommon, although nausea, constipation and drowsiness may occur. *Dosage:* Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

A. H. Robins Company, Richmond, Va. A·H·ROBINS



'head clear upon arising'

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

prescribing information appears on next page

A·H·ROBINS

A.H. Robins Company
Richmond, Va. 23220

Dimetapp® Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.



Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Still serving...

Miltown®
(meprobamate)

WALLACE PHARMACEUTICALS
Cranbury, N.J. 08512

Letters

To the Editor:

As per my telephone call to you last week, the particular reference that I was referring to was Dr. George C. Cotzias' article in JAMA, November 17, 1969, volume 210, page 1255-1262, entitled "Metabolic Modification of Some Neurological Disorders."

Yours sincerely,

MICHAEL M. OKIHIRO, M.D.

The phone conversation referred to above was about the inadvertent dropping of one of Dr. Okihiro's references following his article entitled "L-DOPA and Parkinsonism." It appeared in the September-October issue of the JOURNAL.—ED.

To the Editor:

I saw your editorial about In Memoriam, and I'm overwhelmed. I thought we'd get a paragraph or two at most—this is what my mother used to call the embarrassment of success!

I do thank you for giving our project such wonderful coverage. You gave me much too much credit, but I loved all the nice things you said.

Mahalo,

BETTY KATSUKI

STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

Date of Filing: September 16, 1971.

Title of Publication: Hawaii Medical Journal.

Frequency of Issue: Bi-monthly.

Location of Known Office of Publication: 510 South Beretania St., Honolulu, Hawaii 96813.

Location of the Headquarters or General Business Offices of the Publishers (not printers): 510 South Beretania St., Honolulu, Hawaii 96813.

Names and Addresses of Publisher, Editor, and Assistant Editor: Hawaii Medical Association, Harry L. Arnold, Jr., M.D., Paul Steward, 510 South Beretania St., Honolulu, Hawaii 96813.

Owner: Hawaii Medical Association, 510 South Beretania St., Honolulu, Hawaii 96813.

Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding One Per Cent or More of Total Amount of Bonds, Mortgages, or Other Securities: None.

The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during the preceding 12 months.

CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS
Total No. Copies Printed	1,419
Paid Circulation—Mail Subscriptions	1,075
Free Distribution	302
Total Distribution	1,377
Office Use, Left-Over, etc.	42
Total	**1,419**

Call Us for
OPHTHALMIC INSTRUMENTS

GUILD OPTICIAN
OPTICAL DISPENSERS
of Hawaii, Inc.

532 PROFESSIONAL CENTER BLDG.
1481 SO. KING STREET — 955-6314

1133 BISHOP STREET
HONOLULU, HAWAII — 537-6570

1441 KAPIOLANI BLVD., SUITE 312
HONOLULU, HAWAII — 949-4795

103 PROFESSIONAL CENTER BLDG.
30 AULIKE STREET
KAILUA, HAWAII — 261-6030

Complete Contact Lens Service Available

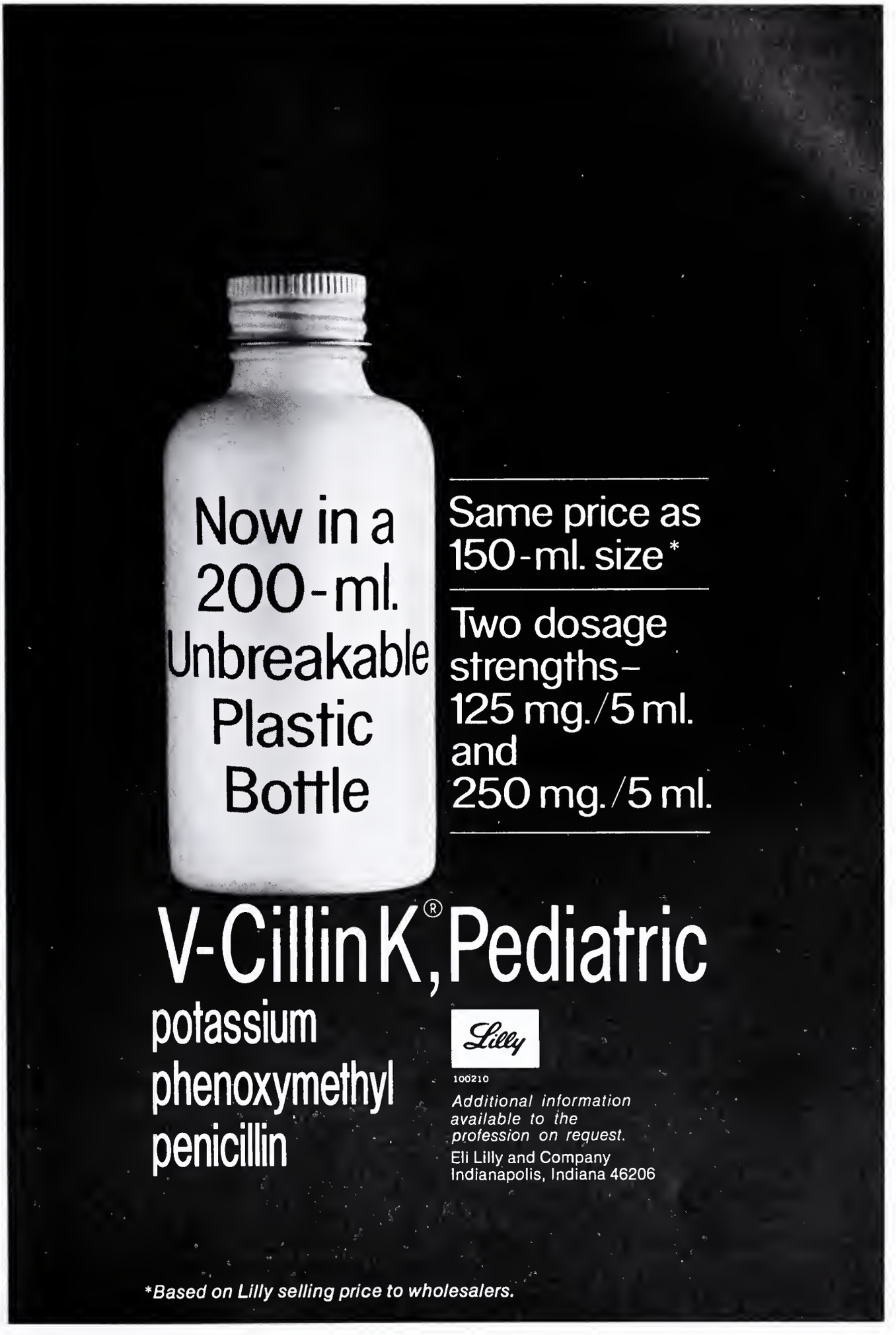
Equipment Distributors for:

CARL ZEISS, INC., BAUSCH & LOMB, AMERICAN OPTICAL CO., SHURON, TITMUS, RELIANCE, WELCH ALLYN, KEELER AND LAWTON INSTRUMENTS.

it's the real thing

Enjoy Coca-Cola Trade-mark ®

COCA–COLA BOTTLING COMPANY
OF HONOLULU, INC.


Now in a
200-ml.
Unbreakable
Plastic
Bottle
Same price as
150-ml. size*
Two dosage
strengths–
125 mg./5 ml.
and
250 mg./5 ml.
V-Cillin K®, Pediatric
potassium
phenoxymethyl
penicillin
Lilly
100210
Additional information
available to the
profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
*Based on Lilly selling price to wholesalers.

Multiple Sclerosis: Autoimmune Disease*

The autoimmune response may have a slightly delayed protective component in addition to its well known tissue-damaging effect

ALLAN CHINEN,† and MITSUO YOKOYAMA, M.D., *Honolulu*

Experimental allergic encephalomyelitis, a laboratory model of an autoimmune disease closely resembling multiple sclerosis, seems to result from an allergic response which has two phases: an initial phase inducing inflammation and demyelinization of nerves, and a slightly delayed phase counteracting the first one. It is suggested that many other autoimmune responses, perhaps all of them, may have such a diphasic nature. The counteracting response, protective in such situations as this, may also account for the fact that not all cancers are recognized as foreign and rejected successfully by the body: some get by and survive, perhaps because this protective response is strong enough to cause them to be spared. If the protective response could be initiated by itself, or enhanced, we might have in it the most effective treatment possible for autoimmune diseases.

CERTAIN DEVELOPMENTS throughout the past years in immunology have awakened an intense interest in the "autoimmune" diseases. These diseases are characterized by an immune system activated against autologous substances in the body, and thus capable of damaging tissue. It is not clear, however, whether this autoimmune phenomenon is due to cellular alterations which make the tissues themselves antigenic to the autologous immune system, or to aberrations in the immune system itself. Many other crucial aspects of differing autoimmune diseases are similarly unclear, and investigation into them continues.

Multiple sclerosis (MS) is one such disease being investigated as an autoimmune disorder of the central nervous system (CNS).[1] Because of the difficulty in studying MS in human patients, however, a laboratory model has been used by many investigators. This model is experimental allergic encephalomyelitis (EAE).

Kuakini Medical Research Institute and Kuakini Hospital.
* This work was supported by the Albert T. and Wallace T. Teruya Foundation.
† Grantee of the Hawaii Heart Association Summer Student Research Fellowship Program. Presently, a student at Stanford University.
Received for publication March 26, 1971.

"CLASSICAL" EAE

EAE is caused by an induced hypersensitivity against the myelin of both the spinal cord and the brain. The disease can be regularly induced in mice, guinea pigs, rabbits, and monkeys, with various genetic strains exhibiting differing susceptibilities. Induction in the classical method is achieved by the injection of homogenized CNS tissue. The tissue, either whole brain or spinal cord, is emulsified in Freund's complete adjuvant. The adjuvant, a water-in-mineral-oil agent containing killed mycobacteria, presumably acts as a hyperimmunizing agent, and a slow-releasing depot for the antigen. Present investigators, it should be noted, have begun altering this classical technique by substituting a purified protein in place of whole CNS tissue. This protein, derived from the myelin sheath, was found to be alkaline, and to contain most of the encephalitogenicity that whole CNS possesses.

Symptomatically, the disease is characterized by severe paralysis after a moderately short incubation period, followed usually by death. Morphological analysis of the CNS in EAE reveals extensive neurological damage, usually lymphocytic infiltration, inflammation, and edema in the nervous tissues surrounding perivascular spaces. The myelin sheaths in these areas, moreover, are extensively destroyed. This damage is generally thought to result from a delayed hypersensitivity reaction against the myelin.

MS AND EAE

The relationship between this experimental disease, EAE, and MS is not yet clearly understood. It appears, though, but equivalence between the two, notwithstanding many similarities, is not precise. The basic similarity between them has heretofore been symptomatic. Both are essen-

tially characterized by the destruction of myelin in visible lesions, with paralysis and death. Whether the two are similar in pathogenesis, however, is still uncertain; though the autoimmune basis of EAE is well-founded, a similar type of mechanism for MS cannot yet be definitely concluded. Recent evidences do, however, point toward such a parallel autoimmune process for MS. Lamoureux *et al*,[2] using rhesus monkeys as subjects, for instance, found a marked elevation in serum IgG for EAE animals, paralleling the demonstration of increased IgG in the brain tissue and CSF of MS patients.[3, 4] Immunofluorescence studies of these MS tissues, moreover, showed this IgG to be concentrated at the margins of demyelinating plaque areas, paralelling animal nervous tissue studies which indicated the localization of demyelinating antibodies around neural membranes.[5] Several major differences which prevent a direct correlation between EAE and MS counterbalance these similarities, however. One striking characteristic of MS, for example, is the pattern of repeated exacerbations of symptoms, followed by a remission phase; EAE by contrast is continually progressive. Morphologically, demyelination of MS CNS tissue is more extensive, too, and is not limited to nervous tissue surrounding perivascular areas, as in EAE.

MODIFIED EAE

Because of these differences, further work is being done to develop modified versions of classic EAE, which will more closely parallel MS. Stone and Lerner,[6] for example, are working with what could be termed chronic EAE. It is basically an attenuated form induced either with weak encephalitogens, or in highly resistant animal strains. The course of disease is protracted, and the mortality rate is low, symptoms similar to those of MS. Differences between CNS lesions produced by this chronic EAE, and the usual EAE indicate the possibility of slightly differing pathogenic mechanisms for each. Levine,[7] as another example, induced repeated attacks of EAE in a single group of animals to simulate the MS cycle. Repeated induction, he found, tends to make the subject animal resistant to later inductions, and he postulated that this was due to the vascular scar tissue which is formed as a result of EAE inflammation. This scar tissue inhibits disease induction by preventing the infiltration of sensitized lymphocytes from vascular spaces to neural tissue, and, Levine suggested, might be a contributing factor to the relatively slow and cyclical progress of MS.

It should be noted at this time, that an alternate theory of MS etiology exists. MS, in this alternate view, is caused by a long-term, slow-acting viral infection, with indications that it is measles virus that is involved. These two etiological theories do not necessarily exclude each other, however. The possibility exists that MS is a genuine autoimmune phenomenon, prompted or enhanced, or both, by a slow-acting virus.

EAE RESEARCH: PATHOGENESIS

Despite this uncertainty over the EAE-MS equivalence, research into the immunological aspects of EAE continues. There are two major areas of investigation—the pathogenic mechanism, and the protective processes. In the study of EAE pathogenesis, the nature of the mechanism involved is not yet clearly understood, although the delayed hypersensitivity phenomenon is generally credited with a major role. Evidence exists, though, which supports some role for humoral antibodies in causing autoimmune damage. The extent to which delayed hypersensitivity and humoral antibodies each operate in pathogenesis, and the relationship between them, is far from clear, and the subject of much research.

The delayed hypersensitivity theory, which attributes autoimmune neural damage to the activity of lymphocytes sensitized against CNS tissue, rests primarily on two phenomena: (1) the successful transfer of EAE from a diseased animal to a healthy subject via EAE-active lymph node cells, and related studies on lymphocyte activity; and (2) the delayed type skin reactivity to myelin basic protein that has been observed in EAE animals.[8] The transfer of EAE with lymph node cells (LNC) called passive transfer, is possible with reasonable reproducibility. This phenomena is attributed to the immune activity of the injected LNC directly against host CNS, and the transferral of immune sensitivity from heterologous to autologous LNC via intercellular contact. Transferral of EAE was possible only between inbred and tolerant animals, and difficult between randomly bred subjects. This was concluded to be due to the viability of the heterologous LNC in inbred animals; randomly bred animals, by contrast, immunologically destroy the introduced LNC.[9]

At the time of the first passive transfers of EAE, however, it was far from clear that LNC activity was responsible for the transfers. An alternate hypothesis attributed passive transfer to the inadvertent administration of antigen contained in the LNC suspension, against which the recipient manufactured autoimmune-directed antibodies. This hypothesis, however, was later ruled out by Falk *et al*,[10] who attempted passive transfer using EAE-active lymphocytes that had been heated to 60°C. a temperature known to inactivate lymphocyte activity but not to eliminate the encephalitogenicity of neural antigen. Passive transfer was

not possible. Cases have also been reported where recipient animals developed a more severe EAE than the donor animal groups,[9] a phenomenon inexplicable by the alternate hypothesis.

Further evidence favoring the delayed hypersensitivity theory over the humoral antibody hypothesis comes from the inability of serum taken from EAE animals to induce the disease in healthy recipients. Studies on LNC activity in diseased animals also tend to support the delayed hypersensitivity hypothesis. Immunofluorescent studies on EAE-active lymphocytes from guinea pigs, for instance, show that these lymphocytes have an affinity for myelin basic protein,[11] indicating immunologic activity against the protein. This affinity, it is important to note, was present in all challenged animals, whether or not clinical signs of EAE were evident. It was not present in animals uninoculated with the encephalitogenic suspension. The affinity for antigen by these EAE-active lymphocytes, moreover, did not appear to be due to absorbed antibody, since normal (non EAE active) lymphocytes incubated in EAE sera did not become sensitized. A direct correlation between skin sensitivity to myelin-basic protein, and EAE severity,[10] in addition, has been noted. Skin sensitivity of this type is known to be a delayed hypersensitivity phenomenon.[12]

These evidences supporting delayed hypersensitivity are paralleled by similar observations indicating some role for humoral antibody. The main support for the humoral antibody hypothesis, which attributes neural damage to the action of antibodies rather than lymphocytes, comes from tissue culture studies. In these experiments, demyelination of nervous tissue by EAE serum has been observed. Demyelination of neural cultures follows a specific and reproducible pattern after contact with EAE serum: neuroglial cells first swell, followed by fusiform and irregular enlargements of the myelin sheath, then ending in the breakdown of myelin into fragments. It is interesting to note that most serum samples from MS patients in acute exacerbation demyelinated mouse cultures of cerebral cortex[13] while normal human serum did not cause such a cytotoxic reaction. Analysis of EAE rabbit sera with rat cerebellar cultures demonstrated a similar myelinotoxic agent. Here, demyelinative capacity was found to be entirely within the gamma-2 portion of the 7S immunoglobulin (ie, in the $7S\gamma2$ fraction).[5]

It should be noted that the major serum immunoglobulin, the $7S\gamma$ globulins, consist of two separate classes: $7S\gamma1$ and $7S\gamma2$. These two differ in their electrophoretic migration rate, $7S\gamma1$ migrating anodally, $7S\gamma2$, cathodally. These two globulins have qualitative differences in biological activity—notably in the ability to mediate passive cutaneous anaphylaxis (PCA) and to fix complement. The first is characteristic of $7S\gamma1$; the second, complement fixation, is found primarily in the $7S\gamma2$ fraction. In the experiment mentioned above, the $7S\gamma2$ was isolated from the EAE rabbit sera. Only one microgram of this $7S\gamma2$ was necessary for *in vitro* demyelination of nervous tissue cultures. The fact that such low titers cannot be detected easily *in vivo* could explain the lack of consistent finding regarding *in vivo* humoral antibodies, which had previously weakened the case for the antibody hypothesis. That the factor which causes neural damage is the complement dependent $7S\gamma2$ globulin is supported by rhesus monkey studies which demonstrated an increase of IgG (or $7S\gamma$) globulin in the serum of EAE animals.[2]

MS, as noted earlier, is also associated with elevated IgG level. Tests on the IgG obtained from MS patients have also confirmed the complement-dependent nature of the demyelinating factor.[13] It was also observed that EAE rabbit sera when incubated with fetal rat liver epithelium and striated muscle cultures produced no visible damage, while incubation of these rabbit sera with brain homogenates, prior to testing for myelinotoxicity, abolished the toxic effect. This indicates that the antibody involved acts with great specificity for neural tissue. Further studies, through immunofluorescence, indicate that the antibody acts directly on the neuroglial membranes, and myelin sheaths,[5, 14] the site of observable neural damage in both EAE and MS. It is evident, therefore, that at least *in vitro* a humoral factor, capable of neural damage, is present. The significance of this observation for the *in vivo* situation cannot be definitely concluded yet, however.

In these tissue culture studies, demyelination has been tacitly postulated to be a direct cause of clinical symptoms. Increasing evidence, however, suggests a more complex relationship between demyelination and the cause of clinical symptoms. An animal may suffer paralysis without, on sacrifice, showing evidence of demyelination. Seil *et al*[15] observed this in the case of guinea pigs hyperimmunized with myelin basic protein, rather than whole CNS tissue, a result also confirmed by our laboratory. The inevitable conclusion was that demyelination is evoked by an antibody to an antigen other than myelin basic protein.

Bornstein and Crain's studies[13] of the bioelectric characteristics of cultured nervous tissue points in a similar direction. They found that non-visible changes in the synapses of cultured tissue occurred immediately after contact with EAE rabbit sera. Visible demyelination and degeneration of the neural tissue followed this synaptic alteration by an appreciable time lag. It is possible therefore,

that antibody specifically against myelin-basic protein produces certain alterations on the neural membrane which block the synapse, but with no visible destruction. Another antibody to slight differing antigen could conceivably be capable, after this first step, of producing visible destruction in the form of demyelination. This hypothesis gains some support from the observation that guinea pigs challenged with emulsified whole spinal cord tended to have more demyelinative lesions than those challenged with a suspension of myelin basic protein. A suspension with whole spinal cord presumably has more neural antigens than a purified suspension of myelin protein would. These additional antigens are those that evoke demyelination.

Further support comes from analysis of CSF taken from MS patients by Yokoyama and Roboz-Einstein.[16] This study revealed three to four versions of $7S\gamma 2$ in the CSF, indicating that some mechanism involving multiple anti-CNS antibodies is present, as has been hypothesized.

Certain consequences, it should be noted, result from this hypothesis. Clinically, it means that acute exacerbation of MS symptoms should precede slightly the visible formation of demyelinating plaques. Moreover, because electron microscopically detectable alterations precede microscopically detectable damage,[13] tissue just beyond the plaque margins should contain evidence of neural membrane damage. A very important experimental consequence of this hypothesis relates to the tissue culture studies previously mentioned. Since demyelination necessarily occurs with synaptic block, but not vice versa, a negative test for demyelination does not conclusively indicate that the serum is EAE–non-active. Inconsistencies that have been encountered with tissue culture studies might be explained by these considerations.

To return to the basic subject, ie, the role of delayed hypersensitivity and humoral antibodies in EAE pathogenesis, the apparent conflict between the two may be resolved slightly with the report by Seil *et al* that a secretant from primitive immunocytes taken from the peripheral blood of EAE-rabbits caused *in vitro* demyelination of rat cerebellar cultures.[15] This was confirmed in the rhesus monkey by Lamoureux *et al*.[2] There is a strong possibility therefore, that neural damage is caused by lymphocytes, but through a humoral antibody mechanism; antibodies cause the actual damage, but these antibodies are produced by lymphocytes.

The present state of experimental results concerning EAE pathogenesis thus points toward a view that synaptic alterations, the cause of clinical symptoms, are followed usually, but not always, by visible neural damage. These damages are induced by the complement-dependent $7S\gamma 2$ antibodies, directed against myelin basic protein and the other antigens found in nervous tissue. These antibodies are presumably formed by circulating lymphocytes, which localize around the antigenic site due to an antigen-affinity.

EAE RESEARCH: PROTECTIVE MECHANISM

Research into the mechanism of induction is only half of the story, however. A comprehension of the protective mechanism which either prevents induction, or suppresses the autoimmune mechanism after activation, is essential. Indeed, of the two categories, investigation concerning the protective aspects of EAE promises to be the most exciting and rewarding. A knowledge of the means to effectively control the immune system in the autoimmune case would have many clinical applications, not restricted merely to EAE or MS. That a protective mechanism is operative is evident from the fact that not all of the challenged animals develop EAE. Genetic considerations enter here, for it has been demonstrated that certain strains of guinea pigs are highly susceptible to induction,



FIG. 1.—*During the incubation of an autoimmune disease, two groups of forces are thought to be in conflict—those involved in induction, as the pitchforked devil is, and those which counteract or prevent it. Development of the disease, EAE or MS occurs when the inductive forces predominate, and remission or prevention when the protective factors predominate.*

while others are highly resistant. As previously mentioned, the lymph node activity of inoculated animals against myelin-basic protein appears to be independent of the animals vulnerability to the disease. Evidently some mechanism counters the anti-CNS activity of the LNC in certain animals, conferring protection. Further support for the protective process hypothesis comes from the studies of rhesus monkeys.[2] The antineural cytotoxicity of serum from EAE animals, as determined by *in vitro* demyelination, climbed rapidly after challenge, reached a plateau after about a week, and then resumed its ascent following a variable time period. Again, some factor apparently counteracted, temporarily, the steady increase in anti-CNS immunologic activity. This is in line with the hypothesis Alvord put forth[17] which postulated a balance between protective and inductive mechanisms in EAE. Protection results when the protective factors predominate, and disease when the inductive mechanism predominates.

There are two general, though by no means all-inclusive, categories of protection indicated in EAE studies: Those that suppress the entire immunological system, usually preventing activation of autoimmune competence, and those that selectively inhibit the autoimmune response, countering an already established reaction. The use of immunosuppressive agents[18] such as methotrexate, large doses of corticosteroids, antilymphocyte serum or antilymphocyte globulin, whole body X-irradiation, severe and prolonged stress, and enforced vitamin C deficiency are examples of the first type of protection. These are all generally understood to suppress the function of the entire immune system. The major drawback they share is that they cannot be used comfortably in autoimmune disease therapy; continued general suppression of the immune system, a highly undesirable situation, would be necessary for control. It is therefore the second type of defense mechanism—the suppression of a single specific autoimmune phenomenon—that is of greatest interest in relation to EAE and MS, and to the field of autoimmune diseases in general.

This second type of protection, although naturally occurring, can also be evoked against EAE in the laboratory. Experimental suppression is obtained by injecting the animal with CNS tissue or myelin basic protein in Freund's *incomplete* adjuvant, ie, Freund's complete adjuvant without the mycobacteria. The injections are usually made (1) before challenge with encephalitogen, (2) after challenge but before the animal exhibits clinical signs, (3) after the animal exhibits clinical signs, or (4) a combination of the above. Freund's adjuvant alone, without CNS tissue or myelin protein, injected in a similar manner, also confers protection against EAE, although to a lesser degree.[20] Investigation with these techniques of protection, and with cases of natural resistance to EAE, have pointed to various sources and mechanisms for inhibition.

In natural protection, ie, non-induced protection, the protective effect appears to be associated with a serum factor present only in challenged animals. Serum from rats recovering naturally after EAE, when administered to challenged rats prior to EAE induction, prevented EAE.[22] The antibody apparently responsible for this protection had complement-fixing characteristics, and appeared to be a 19S immunoglobulin (ie, IgM).[23] In the rhesus monkey studies previously mentioned, the sera from challenged but nondiseased monkeys contained myelinotoxicity that disappeared after 140 days, leaving a protective effect. Sera withdrawn from these animals after 140 days, when mixed with toxic sera from diseased animals, abolished the EAE toxicity.

The protective factor thus appears to be more durable than the demyelinating factor. Whether this is due to durability of the globulin itself, a delay in its manufacture as compared to the toxic factor, a long term nature of production, or a greater concentration of protective rather than toxic antibodies, cannot be determined yet.

Animals experimentally protected by pre-immunization with basic protein in incomplete adjuvant apparently possess a similar serum fraction. This factor was found to be a hemagglutinating antibody in the guinea pig. The titers of this hemagglutinating antibody, which had risen after pre-immunization, fell immediately after the encephalitogenic challenge and then began to rise after the 20th day. The investigators interpreted this to mean that the antibody was utilized in protection during the period of autoimmune sensitization following challenge; its titers thus declined. This protective antibody, unutilized after the "danger" period had passed, was then released, raising the measured titers. This hemagglutinating factor apparently was not a 19S globulin because treatment with 2-mercaptoethanol did not decrease the hemagglutinating titers, although 2-mercaptoethanol is known to split 19S molecules, and presumably abolish its immunologic activity. The investigators did note a large increase in the 19S levels as compared to a lesser one in the 7S mode.

In view of these experimental data, Alvord *et al*[24] postulated that the 7Sγ2 antibody, which characteristically appears after injection, is the damaging complement-fixing antibody, while 7Sγ1, which usually appears after 7Sγ2, and does not fix complement, is the protective antibody. Pro-

tection would be due to the competition for antigenic sites between the demyelinative 7Sγ2 and the non-demyelinative 7Sγ1, both of which would have a high degree of avidity for the neural antigen. Combining Harwin and Paterson's data[23] with those of Alvord *et al*,[24] it is possible to postulate that the 19S globulin also is a protective antibody, with or without marked hemagglutinating properties, depending on the species of animal. Besides joining the competition for antigenic sites in the host CNS after the demyelinative 7Sγ2 is produced, 19S might also partly prevent the manufacture of 7Sγ2. Because 19S appears before the 7S globulins, as the primary immune response, it is conceivable that the 19S could bind with antigen, decreasing the amount of antigenic stimulation which would evoke the secondary response, the 7S globulins. Experimental assays of 7Sγ1 which have failed to detect increases in 7Sγ1 after challenge, a factor which weakens the case for 7Sγ1 as a general protective globulin, might be explicable with a similar mechanism involving antigen-antibody binding. The immediate binding of the protective globulin with the antigenic site would make it undetectable.

INHIBITORY–PROTECTIVE FACTOR?

The implications of a 7Sγ1 globulin antibody with protective aspects, produced shortly after (or contemporaneously with) the 7Sγ2 antibody, could be far-reaching. Is it possible that this protective antibody is present in autoimmune diseases other than EAE or MS? That is to say, is it possible that the production of the antibody which inhibits specific immune phenomena is a general mechanism of the immune system?

A striking and extraordinary parallelism exists here which might prove thought-provoking.

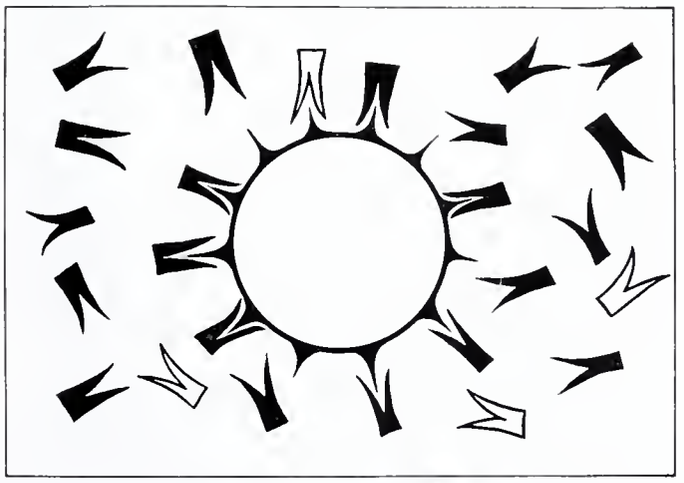
Recent experiments in the field of cancer immunology indicate that the body of a tumor-bearing host produces antibody directed against antigens found only in the tumor tissue, antigens known as tumor-specific transplantation antigens (TSTA). These antibodies against TSTA have been demonstrated *in vitro* to inhibit the growth of tumor cell cultures. It was observed in essence that the immune system of a tumor-bearing host recognizes the tumor as antigenic, and activates itself against it. The question which arose after this observation was why cancer *in vivo* did not regress in all cases, as the invariable anti-cancer immune response of the host would lead one to expect. Hellström and Hellström,[25] working with mice and Maloney sarcoma tissue cultures, demonstrated a serum factor that could abrogate the anti-tumor immune response. In their experiments, the anti-tumor activity was found to be in the lymphocytes which had been taken from mice with either regressing or progressing sarcomas. The anti-tumor activity was measured by the degree the growth of sarcoma tissues was inhibited after the addition of active lymphocytes to the tissue cultures—the colony inhibition test, as it is called.

It should be noted that these lymphocytes were active regardless of whether they were taken from mice with regressing or with progressing tumors, closely analogous to the earlier-mentioned observation from EAE studies that the lymphocytes of all challenged animals exhibited anti-CNS activity.

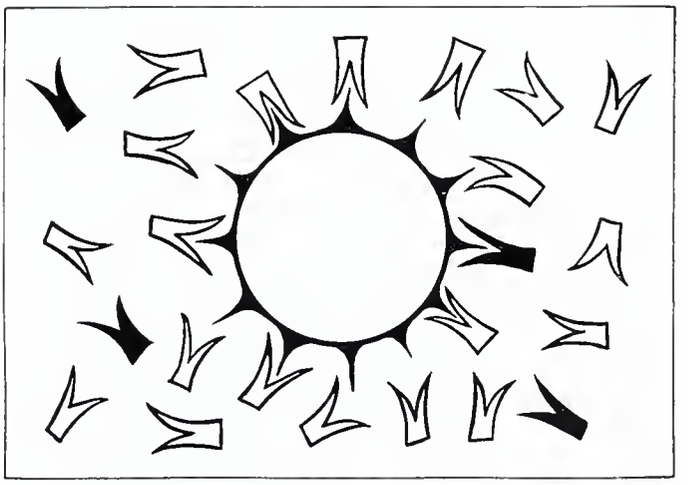
The anti-tumor activity of these lymphocytes, further experiment indicated, was neutralized by

FIG. 2.— ◀ *represents the complement dependent 7Sγ2 antibody thought to be responsible for synaptic block and neural damage in EAE and MS.*

◁ *represents the 7Sγ1 antibody, thought to be the protective serum factor in EAE studies, and a possible candidate for the hypothesized inhibitory-protective factor.*



The case of disease induction: ◀ predominates in population over ◁ and occupies the antigenic sites, ie, the neural membranes. Neurological damage results.



The case of protection against autoimmune disease: Here ◁ has replaced the ◀ on the antigenic sites, halting the destructive process, and protecting the antigenic sites from further immunological destruction.

some factor present in the sera of mice with progressively growing tumors, but not in the sera of mice with regressing tumors; the addition of progressor tumor sera into the sarcoma tissue cultures resulted in cultures whose growth could not be inhibited by active lymphocytes. Apparently, therefore, each cancer-bearing host reacted against and rejected the cancer. In certain hosts, however, another immunological response occurred, inhibiting the first one, and enabling the cancer to progress. This factor, capable of inhibiting immunologically competent LNC, was named the "inhibitory factor" by the Hellströms. It was discovered through a series of tests to be (1) highly specific for the tumor cell type the host carried; (2) operative directly on the tumor cell surface itself, as opposed to the lymphocyte cell surface; (3) of low avidity for the tumor cell surface; (4) most probably a gamma globulin or a globulin fraction. These characteristics are strikingly parallel to those hypothesized and observed for the EAE case.

The similarities suggest that the phenomenon of protective antibody in EAE studies is indeed closely related to the inhibitory factor of cancer immunology. It is thus possible that this inhibitory-protective phenomenon is a general mechanism for the immune system. The possible consequences if this were true are enormous; not the least of them would be the possibility of controlling MS and other autoimmune disorders.

IMPLICATIONS OF THE IPF

The question arises, however, as to the eliciting factor for this inhibitory-protective factor (IPF), assuming it to be a general immunologic phenomenon. It is conceivable that the production of IPF might be elicited by the breakdown of tissue. The immune system, detecting evidence of autoimmune damage, as in the EAE and MS situation, would produce the protective antibody as a response. Protective antibody production would thus follow the manufacture of antiautologous tissue antibodies and first evidences of tissue damage. In an experimentally induced autoimmune disease, such as EAE, the injection of whole homogenized CNS tissue, ie, greatly damaged neural tissue, might evoke the production of protective antibody at the same time that hypersensitivity is induced.

This hypothesis would explain the protection that can be experimentally conferred by preimmunizing the test animals with homogenized CNS tissue in incomplete adjuvant. Presumably the lack of complete adjuvant hinders the development of hypersensitivity, while the presence of a tissue homogenate evokes the protective response.

Whether or not this is the mode of stimulation, another question arises. What controls this IPF immune response? If one continues in the line begun by Alvord's hypothesis of a battle between inductive and protective mechanisms in autoimmune diseases, it is obvious that the factor responsible for protection is the key to treatment of the disease. Knowledge of the determinants of the IPF phenomenon is thus very important, and would have many therapeutic-related consequences. It appears that genetic background is one of the IPF determinants, as evidenced by strain-dependent susceptibility in EAE. Exactly what this genetic determination is, however, is open to question. Were genetics a major factor in determining the postulated IPF response, it is extremely likely that an animal that had naturally recovered from one autoimmune disease should be able to recover from another, totally differing one—given, of course, sufficient convalescent time.

Another question which arises is whether or not the hypothesized IPF phenomenon is evoked in the case of infection. This certainly does not seem likely; the real question is how the body determines the difference between foreign infectious antigen, and autologous elements. This discrimination may be due to an immunologic memory factor. Contact with autologous tissue at the neonatal stage, a time known to be conducive to the development of immune tolerance, may perhaps stimulate the production of IPF to those autologous tissues, and imprint that memory on the immune system. An immune system would thus produce the IPF only to its autologous tissue, and those few external antigens contacted during the neonatal period. Antigens encountered later would not be protected, and hence would be destroyed by the immune system.

The protective nature of the theoretical IPF, the opposite of what is usually expected of antibody activity, could be explained by its complement-independent nature. The complement factors, it must be noted, are known to play an important role in the lytic processes of the immune system. The demyelinating and anti-TSTA antibodies possess their destructive properties because these antibodies involve complement, in this view. The IPF, not involving complement, does not produce destruction. This explanation gains some support from the observed complement-dependent nature of the demyelinating agent, and the lack of it for the protective agent, in EAE studies, and the complement-independency of the protective factor in Hellström's study.

The viral theory of causation for MS and certain cancers would not disagree extensively with this network of hypotheses. It is conceivable that a viral infection may alter autologous cells sufficiently for the host immune system to recognize them as an antigen, thus eliciting the anti-autolog-

ous response to that altered tissue. In the case of viruses which promote the growth of the cell, and in which the IPF is not evoked, or is ineffective, a cancer is the conceivable result. In those cases where the virus does not alter the growth rate, but changes certain other aspects, and where the IPF is not operative, an autoimmune disorder may be the result. If the virus-caused changes were extensive, the hypothesized IPF phenomenon would, moreover, be ineffective. The IPF (produced, as hypothesized earlier, according to a memory of normal cellular structure) would bind most strongly only to normal tissue, and would not bind with as great avidity on the altered antigenic site. The destructive antibodies, by contrast, whose production is tailored to fit the altered antigenic sites, would have great avidity. This would explain the low avidity Hellström and Hellström found for the inhibitory factor of their cancer studies, and the low incidence of spontaneous regressions in cancers. It is interesting to note at this point in discussing possible viral involvement for autoimmune diseases, that interferon has been found in the brain of one patient who died from MS.[26] Interferon production by the body is elicited only by viruses, certain bacterial endotoxins, and specific chemical stimulators, as far as is presently known. A view involving viral involvement in autoimmunity cannot therefore be rejected offhand.

Further deductions and conjectures concerning both the theory and the clinical therapeutic aspects of the IPF phenomenon are limited only by imagination, and, of course, whether this IPF phenomenon exists.

SUMMARY AND CONCLUSION

It is evident in conclusion, that the investigations into EAE have proved to be both fruitful and promising. The present state of experimental results have yielded the general, basic outlines of the nature of EAE, especially in regard to the pathogenic and protective mechanisms, although complete understanding is not yet possible. The symptomatic similarities between EAE and MS, moreover, have pointed toward etiological parallelisms. If this is true to a significant extent, the body of EAE research would yield many practical, clinical results. A striking parallelism between immunological aspects of cancer and EAE points, in addition, toward the possibility of several very significant immunological concepts which could conceivably result in new methods of controlling autoimmune diseases. In essence, therefore, the basic research work in EAE forms a foundation from which important clinical, and conceptual results can be derived, related to MS in particular and the autoimmune diseases in general. The development of these results from their basic state, a project for the immediate future, promises to be a very exciting one.

ACKNOWLEDGMENTS

We wish to thank the Hawaii Heart Association and the Teruya Foundation for their grants which made this study possible.

REFERENCES

1. Kies MW, Alvord EC, Show CM: Anti-brain antibodies, *NINDB Monograph* No. 2, 1967.
2. Lamoureux G, Burlay G, Bordreas A: A cytotoxic antibody for cultured nervous tissue in serum and cerebrospinal fluid from rhesus monkeys with allergic encephalomyelitis, *Clin exp Immunolo* 1:307-321, 1966.
3. Tourtelotte WW: Multiple sclerosis: the hunt for etiology, Hospital Practice 4:29-33, 1969.
4. Sherwin AC, Karpati G, Laviolette R: The blood-cerebrospinal fluid barrier to antibody in experimental allergic encephalomyelitis and neuritis, *Rev Canad Biol* 13:24-29, 1965.
5. Appel SH, Bornstein MB: The application of tissue cultures to the study of experimental allergic encephalomyelitis: II: serum factors responsible for demyelination, *J Exper Med* 119:303-312, 1964.
6. Stone SH, Lerner EM: Chronic disseminated allergic encephalomyelitis in guinea pigs, *Ann NY Acad Sci* 122:227-238.
7. Levine S: Allergic encephalomyelitis—cellular transformation and vascular blockade, *J Neuropath Exper Neurol* 29:6-20, 1970.
8. Falk GA, Heinze RG, Kies MW et al: Skin-fixing antibodies in experimental allergic encephalomyelitis, *J Immun* 100:321-328, 1968.
9. Stone SH: Transfer of allergic encephalomyelitis by lymph node cultures in inbred guinea pigs, Science 134:619-620, 1961.
10. Falk GA, Kies MW, Alvord EC: Delayed hypersensitivity to myelin basic protein in the passive transfer of experimental allergic encephalomyelitis, *J Immunol* 4:638-644, 1968.
11. Rauch HC, Raffel S: Antigen uptake by specifically reactive cells in experimental allergic encephalomyelitis, *Ann NY Acad Sci* 122:297-307, 1965.
12. Sibley WA, Tourtelotte WW: Delayed skin sensitivity to human encephalitogen in experimental allergic encephalomyelitis, Nature 214:1021-1022, 1967.
13. Bornstein MB, Crain SM: Functional studies of cultured brain tissues as related to demyelinative disorders, Science 148:1242-1244, 1965.
14. Bornstein MB, Appel SH: The application of tissue cultures to the study experimental allergic encephalomyelitis: I. patters of demyelination, *J Neuropath Exper Neurol* 20:141-157, 1961.
15. Seil FJ, Falk GA, Kies MW, Alvord WC: The *in vitro* demyelinating activity of sera from guinea pigs sensitized with whole CNS and with purified encephalitogen, *Exper Neurol* 22, 1968.
16. Yokoyama M, Roboz-Einstein ER: Immunochemical analysis of cerebrospinal fluid, *Ann NY Acad Sci* 122:439-454, 1965.
17. Alvord EC: Pathogenesis of experimental allergic encephalomyelitis: introductory remarks, *Ann NY Acad Sci* 122:245-255, 1965.
18. Brandriss MW, Smith JW, Friedman RM: Suppression of EAE by anti-metabolites, *Ann NY Acad Sci* 122:356-368, 1965.
19. Levine S, Sowinsky R: Reduction of allergic encephalomyelitis incubation period to 5 days, *Amer J Path* 54:97-107, 1969.
20. Lisak RP, Kies MW: Mycobacterial suppression of delayed hypersensitivity in experimental allergic encephalomyelitis, *Proc Soc Exper Biol Med* 128:214-218, 1968.
21. Lisak RP, Heinze RG, Kies MW, Alvord EC: Antibodies to encephalitogenic basic protein in experimental allergic encephalomyelitis, *Proc Soc Exper Biol Med* 130:814-818, 1969.
22. Caspary EA, Sinden RE, Field EJ: Some observations on the role of circulating antibody in protection against experimental allergic encephalomyelitis, *Z Immunitat Allergie u klin Immunol* 130:454-460, 1969.
23. Harwin SM, Paterson PT: Antibrain antibodies of the 19S-γ globulin type in rats with allergic encephalomyelitis, Nature 194:391-392, 1962.
24. Alvord EC, Shaw CM, Fahlberg WJ, et al: An analysis of various types of inhibition of experimental allergic encephalomyelitis in the guinea pig, *Z Immunit u Allergie* 126:217-277, 1964.
25. Hellström I, Hellström KE: Studies in cellular immunity and its serum mediated inhibition in moloney virus induced mouse sarcomas, Personal Communication to Dr. Mitsuo Yokoyama.
26. Sibley WA, Tourtelotte WW: Interferon assay of MS tissue, *Trans Amer Neurol Assoc* 93:133-136, 1968.

Performance Specifications of an HMO

Socioeconomic Intelligence

MRS. H. H. CHUN, R.N., *Honolulu*

HEALTH MAINTENANCE Organizations or HMO's constitute a self-regulatory, pluralistic, highly diversified, competitive, and market-oriented organized system of health care.[1] It is a single management vehicle that either arranges for or provides primary care, hospital ambulatory care, acute in-bed hospital care, nursing home, and extended-care-facility care, rehabilitation, chronic care, and home care. It is single in the sense that it can insure a proper mix of facilities to meet specific needs of members and provide easy access to each type of care for each physician in the system.[2]

It must guarantee primary care that is available and accessible, efficiently and effectively, 24 hours a day. This care can take place either in an urban setting or rural family health centers, and is the route of entry into the system. Primary care means continuous provision of diagnostic, preventive and curative medicine, health maintenance, dental care, and mental care, to families, coordinated in such a way that a physician or a medical team is fully responsible for total care of the patient and his family.[2] It must guarantee continuity of care from primary to specialties as demanded by the patient's condition. Care must be comprehensive in the sense that it encompasses health maintenance and preventive, acute, restorative and chronic care, with extended care[3] "until death do us part."

Payment mechanism and cost control should be within everyone's means. Prepaid capitation, at rates agreed upon before illness is incurred, should include contractual agreements which assure that the provider will share the financial risk of ill health with the consumer. HMO's will make necessary investments in manpower training, capital facilities, and research in health care delivery, consistent with the needs of their consumers. Overbuilding and wasteful use of manpower will be discouraged. Thus, profitability is a condition of survival, and efficient health organizations that manage well will survive.[1]

Health maintenance and promotion, prevention of illness, and education of the public must be stressed. "Educate and encourage each citizen to develop sensible health practices."[4] A vital role of HMO's must be to educate the public as to what kind of health services can be provided and what cannot be provided in the way of health care; it must endeavor to inform and educate consumers as to which services are needed. "The public must know that simply paying the bill for illness will not provide the system of superior care that it seeks and medicine can deliver."[5] Promotion of health can be encouraged through continuing education by means of informational programs, visual aids, and other presentations made available in health centers, well-baby clinics, and other care facilities.[6] Prevention can be implemented through periodic physical examinations, with the assistance of multiphasic screening systems or other more traditional methods.[7] Physicians must be trained to deliver comprehensive care in much the same way that specialists deliver hospital care. Physicians and medical students can be trained in patient care laboratories, outpatient clinics, and neighborhood health centers in delivering care to families, with emphasis on preventive care.[2]

HMO's must offer quality care. To insure that quality is maintained at a high level, it must be subject to peer review and Professional Standards Review Organizations.[8] Moore has suggested consumer oriented grievance committees as a mechanism for maintenance of high levels of quality.[9] There must be conformity with current and existent laws concerning licensure and certification of professional as well as allied health manpower personnel.

Mrs. H. H. Chun is currently a Graduate Student at the University of Hawaii, School of Public Health, Comprehensive Health Planning Program.
Received for publication May 11, 1971.

Representation in this system must comprise all levels in the community. A broad base of community interest must be represented in its Board of Directors. Medical, government, business, and consumer interest must all be represented. The medical interest establishes the methods and program of care available. The government representatives can assure population representation and participation and act as a conduit for federal funds. Business could provide the management talents and insure a properly financed and managed organization. And most of all the consumer group must have meaningful participation in the planning and operation of the care facility, its programs, goals, and functions, and insure responsiveness to community needs.[10]

The entire system must be under a single management corporation to insure entry into the system at the most advantageous point for the patient. The personal physician, backed up by a whole team of group practice with 24-hour accessibility, has complete access to this comprehensive system of services, medical records, diagnostic facilities, consultations, hospital beds, the newest scientific knowledge, and will refer patients according to what is best for them. In the end it will prove more economical and advantageous, as there will be no duplication. It will have centralized purchasing, billing, and record keeping.[3]

To succeed, this system must be fully financed by those paying for the service, and not dependent on federal funding. For the low income, the poor, and near poor families who lack adequate financial resources, the federal government's Family Health Insurance Plan would be the answer toward the goal of assuring all Americans financial access to health care.[11] Another mechanism for funding would be National Health Insurance if it finally becomes a reality. In either case creation of the facilities needed for this system would come from government grants, foundations, corporate gifts, or loans from private developers. Loans and grants for initial capital are promised by the President: "An organization could receive up to $500,000 to plan to start an HMO . . . The government will guarantee up to $300 million in private loans next year to establish HMO's and within the next four years it hopes to guarantee up to $2 billion."[4] Primary care facilities now in existence could have contractual relations with HMO's which would guarantee comprehensive health services available at all times (ie, beds, diagnostic labs, operating suites, etc.). HMO's can be sponsored by either medical foundations, community groups, profit or non-profit groups or some other financial institutions. "HMO's may be hospital-based, medical-school-based, or a free standing outpatient facility or group of facilities."[12]

HMO's, though conceived as autonomous non-profit organizations, must have affiliation with existing business institutions, hospitals, medical centers, and medical schools, and seek their sponsorship. The body of knowledge that comes from these institutions in managerial know-how and latest scientific discoveries will contribute to the development of an economic operation and an efficient, progressive health delivery system.[2] Legislators and other officials at the local, county and state level must be sought out and involved, since political decisions affect health care.[13]

The HMO concept is an attempt to help the medical profession and other providers to take the initiative in improving the organization and delivery of health services.[11] The two major thrusts of the Nixon Administration in encouraging the HMO concept are (1) improvement of accessibility, and (2) cost containment.[14]

Olson has stressed the necessity for obtaining understanding and acceptance by health professionals, especially physicians, of the new approaches to the delivery of health care, and suggests that new methods will continue to evolve slowly, irrespective of how the financing of that care is arranged.[15] Recognition by the administration of the virtues of an evolutionary approach to change was recently reflected by Dr. Ellwood, who, in stressing the pluralistic delivery options, estimated that perhaps fifty per cent of health care would be delivered by means of HMO's in the next ten years.[16]

REFERENCES

1. Ellwood PM Jr: The Health Maintenance Strategy (Position paper from the Institute of Interdisciplinary Studies, Minneapolis). American Rehabilitation Foundation, October 7, 1970 (revised).
2. Cronkhite LW Jr et al: A Health Care System for Massachusetts. *New Eng J Med* 284:240-243, 1971.
3. Saward EW: The Relevance of Prepaid Group Practice to the Effective Delivery of Health Services. *The New Physician* 18:39-43, 1969.
4. "President's View of Medicine." Medical World News pp 20-21, March 5, 1971.
5. Code CF: Determinants of Medical Care—A Plan for the Future. *New Eng J Med* 283:679-685, 1970.
6. Garfield SR: The Delivery of Medical Care. Scientific American 222:15-23, 1970.
7. Garfield SR: Multiphasic Health Testing and Medical Care as a Right. *New Eng J Med* 283:1087-1089, 1970.
8. "MDs foresee a national health program, but fear it will weaken quality of care." American Medical News p 9, March 1, 1971.
9. Moore TG Jr: "Current Activities of Labor Relative to Changes in the Health Industry." Lecture, Univ Hawaii to students of PH 613, March 15, 1971.
10. Turner 1: "Mile Square Neighborhood Health Center in Chicago." Lecture, Univ Hawaii to students of PH 613, March 16, 1971.
11. Cavanaugh JH: Proposed HMO and FHIP Programs can Improve System. Hospital Progress 52:26-29, 1971.
12. Health Maintenance Organizations—the concept and structure. U.S. Department of Health, Education and Welfare, Health Services and Mental Health Administration.
13. Falkson JL: "Citizen Participation in Health: Control or Cooptation?" Lecture, Univ Hawaii to students of PH 613, April 27, 1971.
14. Smith WM: Open meeting sponsored by Univ Hawaii School of Public Health, May 5, 1971.
15. Olson SW: Health Insurance for the Nation. *New Eng J Med* 284:525-533, 1971.
16. Ellwood PM Jr: Address on HMO's. Ala Moana Hotel, Honolulu, Hawaii, April 19, 1971.

The Activated Coagulation Time Test as a Control for Heparin Therapy

PATRICIA CHO, FRANK BONILLA-LINERO and EVELYN YIM, *Honolulu*

The Activated Coagulation Time (ACT) has been compared with the classic Lee-White (L-W) method in a study to determine its value for the bedside control of heparin therapy.

Our tests have shown, on twenty blood samples, that the ACT correlates closely to the L-W time with the advantage of being an easier and shorter test to perform. After repeated tests on several patients, we found that the therapeutic range of the ACT was 3 to 3½ minutes as compared to a range of 25 to 45 minutes for L-W times. The normal range for the ACT, established from 22 normal individuals, was 1 minute 51 seconds to 3 minutes 3 seconds. The maximum ACT time was 6 minutes as compared to the L-W time of 84 minutes.

Our study has shown a close relationship between the two methods and indicates that the ACT may replace the L-W time for the bedside management of heparin therapy.

THE LEE-WHITE (L-W) Coagulation test, used frequently to control patients on heparin therapy and to diagnose coagulation defects, is time-consuming, inaccurate and cumbersome.[4]

Various investigators have described tests which had advantages not found in the L-W. Dagnon *et al* worked with the Activated Partial Thromboplastin Time (APTT) and found it more accurate than the L-W in response to heparin dosage.[2] Blakely modified the APTT and described the Heparin Assay Rapid Easy Method (HAREM) test, a simpler and more rapid test than the L-W.[1] Franco discovered Celite, an inert diatomaceous earth, to be sensitive to platelet deficiencies when used as a substitute for partial thromboplastin.[3] The greater sensitivity and reliability of the Activated Coagulation Time (ACT) utilizing Celite over the L-W, for detecting Factors VIII and XII deficiencies and for the degree of heparinemia, was demonstrated by Hattersly.[4]

The purpose of this study was to determine the feasibility of the ACT test in the regulation of heparin therapy using the L-W test[5] as a base for coagulation comparison.

MATERIALS AND METHODS FOR ACT TEST

Materials:

Two 5 ml syringes, 1 needle, tourniquet, two glass test tubes, non-siliconized 10 x 75 mm, each containing 6 mg Celite, portable 37°C. water bath, stopwatch.

Method:

1. Place 2 test tubes in the water bath (37°C.) before drawing the blood.
2. Apply tourniquet to fill the vein. Do not have the patient make a fist as this will only produce more tissue juice and may interfere with the results.
3. With the first syringe, draw 1 ml blood. With the needle still in the vein, release tourniquet and draw another 1 ml blood to insure the removal of any tissue juice in the needle.
4. With the needle still in the vein, unscrew the syringe and replace it with the second syringe. Aspirate and as soon as blood contacts the syringe, start the stopwatch.

From U.S. Army Tripler General Hospital.
During the course of the project, the authors were students in medical technology from the University of Hawaii.
Received for publication May 5, 1971.

5. Draw at least 3 ml blood and withdraw the needle.

6. Remove needle from syringe. Add 1 ml blood to each of the 2 test tubes being incubated. Tilt each tube to 45° several times to insure complete mixing with Celite. The drawing of blood to the time of mixing should be complete within 1 minute.

7. Tilt the first tube every 5 seconds, but keep the tubes at 37°C.

8. When a clot has formed in the first tube, begin tilting the second tube in the same manner.

9. When a clot has formed, stop the stopwatch and note the time.

RESULTS

Hattersly[4] reported that varying the amount of blood and diatomaceous earth did not alter the ACT appreciably. However, in our first series of tests on 32 blood samples from heparinized patients, we found poor correlation between the L-W and ACT results when 2 ml of blood were added to varying quantities of Celite. The Celite and 2 ml of blood were difficult to mix thoroughly within 1 minute which contributed to the variability. Since our purpose was to find a time-conserving method which correlated well with the L-W test, we used less Celite (6 mg) and less blood (1 ml). This modification produced a similar pattern to the L-W results when tested on 20 samples.

Two studies of known heparin dilutions in whole blood demonstrated that the L-W and ACT times increase proportionately to the heparin dilution. Figs. 1, 2.

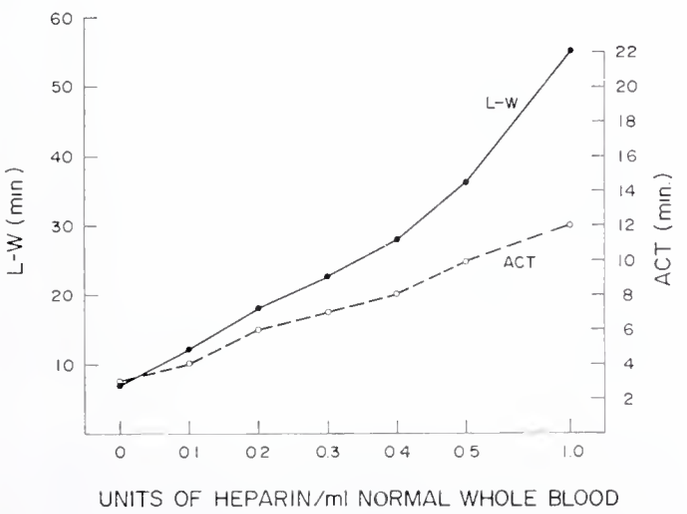


FIG. 1.—*First comparative study of L-W and ACT tests in vitro.*

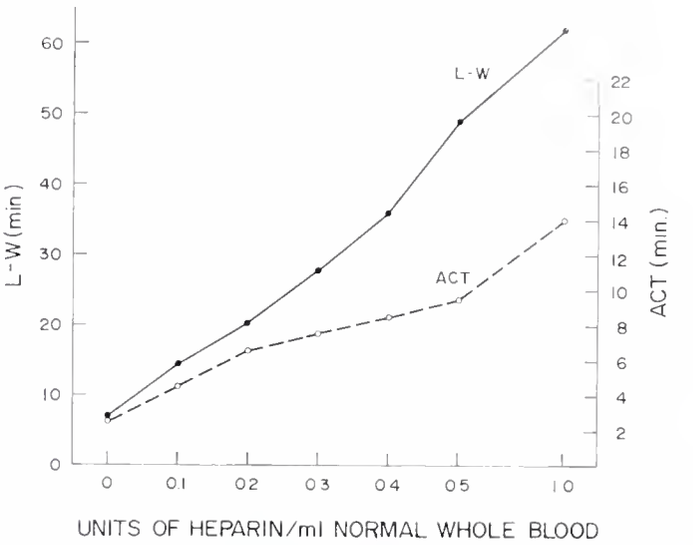


FIG. 2.—*Second comparative study of L-W and ACT tests in vitro.*

Twenty-nine tests were done using both methods on heparinized patients. The patients' ACT times were shorter than those done when heparin was added to the normal blood *in vitro*. In a heparinized patient, a 48 minute L-W time gave an ACT of 5 minutes, whereas, the same L-W time of normal blood mixed with heparin *in vitro* corresponded to an ACT of 9 minutes.

A frequency distribution of both methods from tests on normal individuals produced our L-W mean clotting time of 15 minutes ± 8 minutes (2 SD) and the ACT mean of 2 minutes 27 seconds ± 36 seconds (2 SD).

In 20 tests done on heparinized patients, L-Ws over 25 minutes gave ACT values over 3 minutes. L-W clotting times of patients in the range of 43

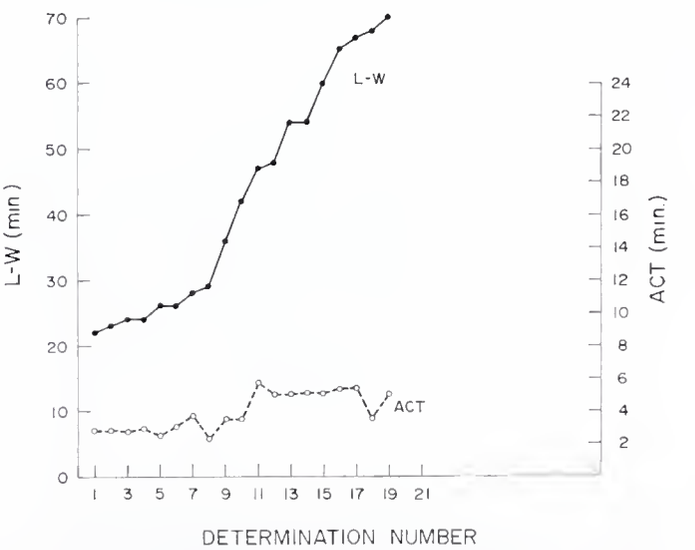


FIG. 3.—*Comparative times of L-W and ACT tests on heparinized patients.*

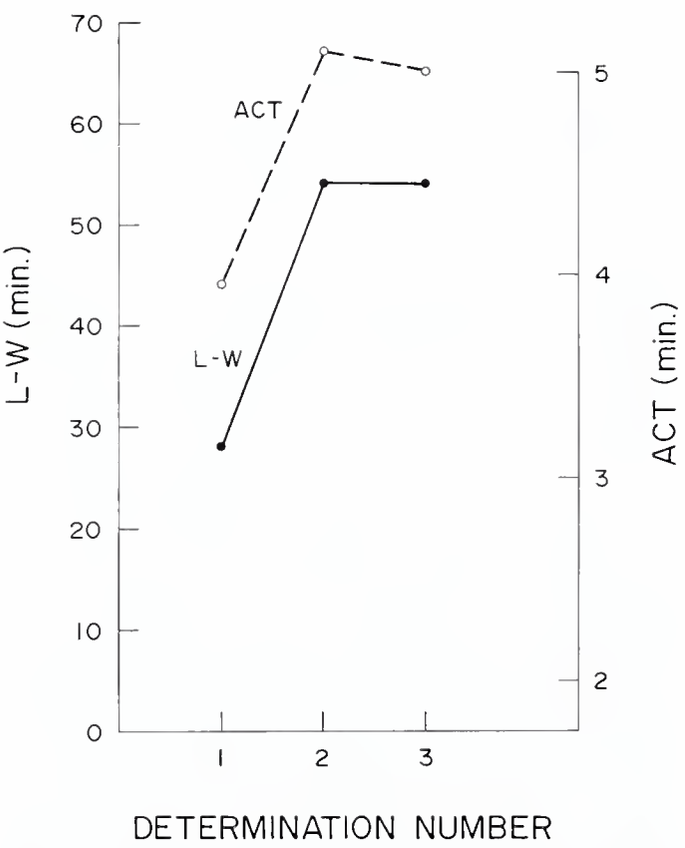


FIG. 4.—*L-W versus ACT tests on a heparinized patient.*

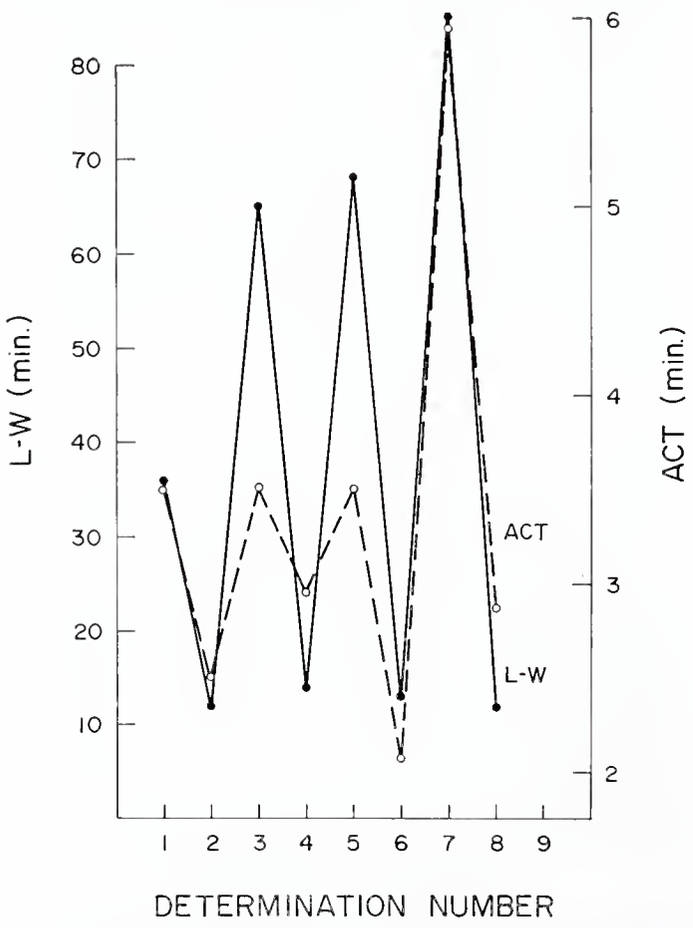


FIG. 5.—*L-W versus ACT tests on a heparinized patient.*

to 84 minutes (therapeutic range of 25 to 45 minutes) corresponded to ACTs between 5 and 6 minutes. Fig. 3.

Seven heparinized patients were tested over a period of time ranging from 3 to 14 days. Of the seven, five who had ACTs in the therapeutic range of 3 minutes to 3 minutes 30 seconds also had L-Ws in the therapeutic range of 25 to 45 minutes. When the L-Ws were under 25 minutes, ACT values were below 3 minutes. Figs. 4-8.

DISCUSSION

Our study has demonstrated that the ACT is a useful method for the control of heparin dosage. It is convenient to use at the patient's bedside and produces a shorter clotting time than the L-W.

In Hattersly's report, the ACT mean was 2 minutes 27 seconds. We ascribe the difference to the modifications we made in Hattersly's method. We did not use tubes evacuated to draw 2 ml of blood and containing 12 mg of diatomite as was done in Hattersly's study. Also, Hattersly used inert diatomite manufactured by the Becton-Dick-

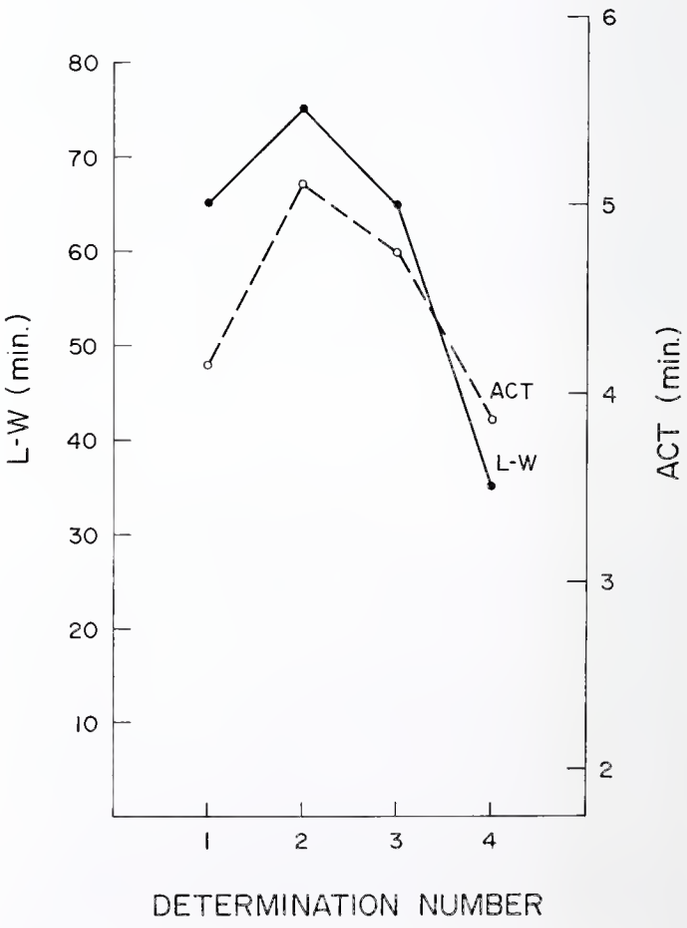


FIG. 6.—*L-W versus ACT tests on a heparinized patient.*

enson and Company, whereas our Celite came from the Johns-Mansville Company.

The ACT variabilities we encountered could have been due to the occasional difficulty when drawing blood from traumatized veins resulting in poor blood flow. The temperature of the water bath could have been another factor though we tried to keep it at 37° throughout the test.

In Figure 3, we considered the initial portion of the graph which ranged from 2 minutes to 6 minutes on the ACT time and 22 minutes to 48 minutes on the L-W time, showing good correlation, significant and of particular interest because within this area was the therapeutic range. The graph continued on to show prolonged L-W times up to 70 minutes whereas the ACT time showed a plateau at 6 minutes. We included this to show the advantage of the ACT over the L-W which would have had a very long time outside of the therapeutic range.

The use of a standard time was not considered during the course of the study on the premise that whether blood be drawn 30 minutes or 2 hours

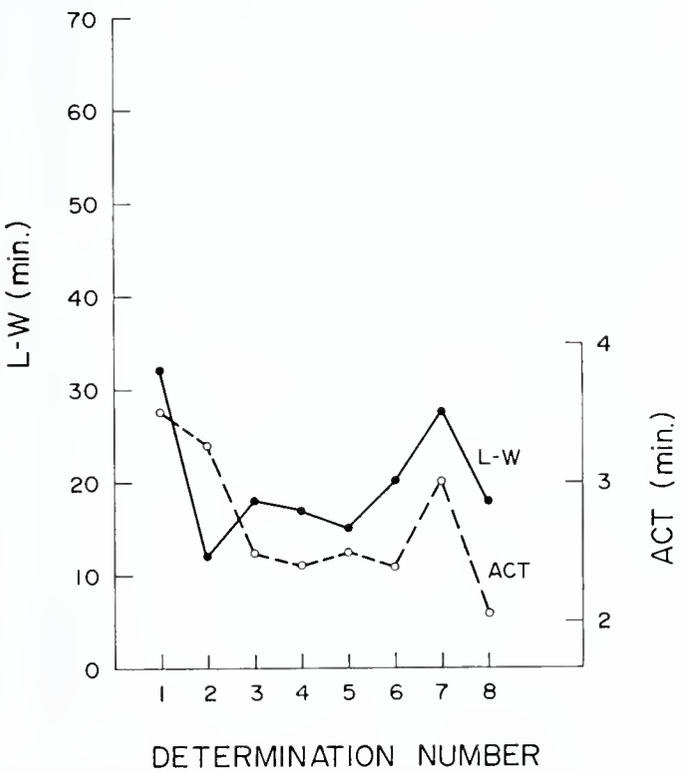


FIG. 7.—*L-W versus ACT tests on a heparinized patient.*

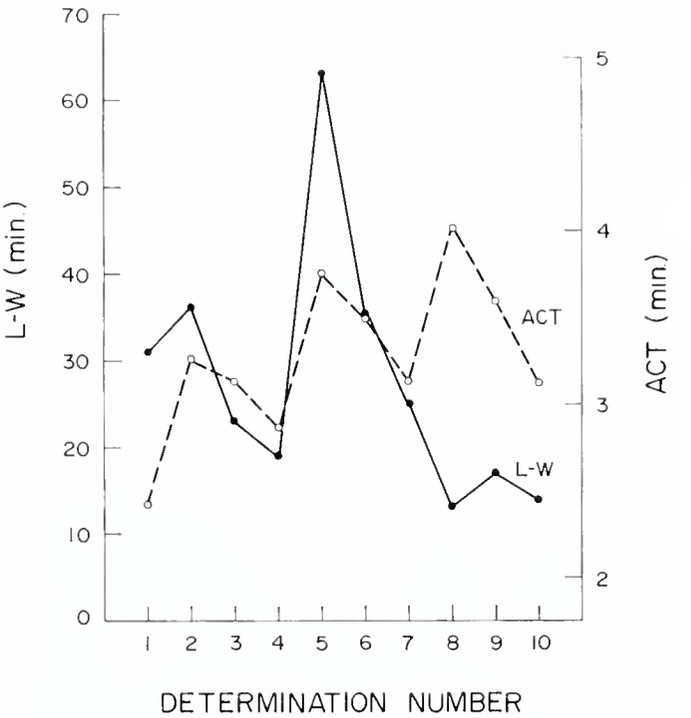


FIG. 8.—*L-W versus ACT tests on a heparinized patient.*

from the administering of heparin would not matter. We were comparing the relationship of the 2 methods and did not feel that the time would have affected the relationship.

This study has demonstrated the usefulness of the ACT and its promise of replacing the time-consuming L-W method. We have shown that the test is simple, easy to perform, requires minimal supervision and is reproducible even in the most inexpericnced hands. Yet, the ACT method should be utilized on a large group of patients in order to insure its value as a control for heparin therapy at the patient's beside.

ACKNOWLEDGMENTS

The authors would like to extend acknowledgments to:

Col. John Hardman for his guidance and supervision without whose initial suggestion the organization of the project would not have been possible.

Edith Eckstein and Patricia Taylor for their suggestions, advice and encouragement.

Medical Technology Department of the University of Hawaii for the graph reproductions.

REFERENCES

1. Blakely, JA: A rapid bedside method for the control of heparin therapy. *Canad Med Ass J* 99:1072-1076 (December) 1968.
2. Dengan, TG, Darakid, SA and Lenahan J: Laboratory control of heparin therapy with the activated partial thromboplastin time test. *Curr Ther Res* 11:390-396 (June) 1969.
3. Franco, Jorge: The celite clotting time. *Clin Res* 13:272 1955.
4. Hattersly, PG: Activated coagulation time of whole blood. *JAMA* 196:436-440, 1966.
5. US Department of the Army: Coagulation time. Laboratory procedures in clinical hematology. TM 8-227-4 p 6-6 (March) 1963.

Addict Detoxification in a Community Hospital

Review of the First 100 Cases

GEORGE W. STARBUCK, M.D., JOHN J. HERGENHAN, B.S., and
MARY C. HALLORAN, M.S., *New Bedford, Massachusetts*

The community hospital is useful in treating drug addicts. When working with Mental Health, they are a stronger force in attacking problems of drug abuse. Mental Health should purchase services from the Community Hospital to avoid duplication. Structured mental health rehabilitation must be available. Population served should be large (100,000 or more). Drug legislation needs changing, for instance, consent for treatment of the minor, reporting of addicts, and other laws.

PERHAPS UNIQUE in the treatment of drug addition is the role played by St. Luke's Hospital in New Bedford, Massachusetts. The hospital recognized a community need and responded by developing a drug detoxification center.

In the fall of 1969, the Mental Health Clinic in New Bedford was granted $26,000 to develop a drug dependency program. A local group known as Aid for Addicts appealed to the Commissioner of Public Health for funds to support a program that would attack the drug addiction problem in the greater New Bedford area. The initial work done by this group triggered the procedures which resulted in the award of the above grant to the New Bedford Mental Health group.

The director of the New Bedford Mental Health Clinic selected two alert workers in the field of drug addiction, one to direct the drug dependency unit and one to work in the field of rehabilitation. They had worked with heroin addiction in New York City.

Within two weeks they uncovered 87 heroin addicts in New Bedford. Therefore, a recommendation that a detoxification clinic be established seemed justified. Subsequent tabulations in Tables 1 and 2 dramatically emphasize that their recommendation was correct.

From the Detoxification Clinic of St. Luke's Hospital, New Bedford, Massachusetts, and the Drug Dependency Unit of the New Bedford Mental Health Clinic. (Address reprints to George W. Starbuck, M.D., Kauikeolani Children's Hospital, 226 North Kuakini Street, Honolulu, Hawaii 96817).

Received for publication February 18, 1971.

TABLE 1.—*Comparison breakdown of the addicts' age.*

	NUMBER OF ADDICTS PER AGE						
Age	4/27	3/23	2/27	2/23	1/30	1/1	Increase Over Last Report
15	7	6	6	6	6	3	+1
16	15	13	11	10	6	3	+2
17	38	36	28	25	12	7	+2
18	53	52	50	41	33	27	+1
19	53	52	46	43	31	22	+1
20	41	39	36	29	21	14	+2
21	35	34	32	28	19	14	+1
22	33	32	31	22	19	14	+1
23	21	19	18	16	14	12	+2
24	19	19	17	11	10	6	+0
25	13	12	12	10	9	7	+1
26	9	9	9	7	4	3	+0
27	4	3	3	3	1	1	+1
28	4	3	3	3	1	1	+1
29	3	3	1	1	1	1	+0
30	2	1	1	0	0	0	+1
31	4	4	3	3	2	0	+0
Unknown	2	2	2	1	3	1	—
TOTAL	356	339	307	260	185	137	+17

TABLE 2.—*Comparison breakdown of sex and median age of addict population.*

SEX	ADDICT CASES
Female	68
Male	288

DATE	NUMBER OF ADDICTS	MEDIAN AGE
1/ 1/70	136	19.70
1/30/70	182	19.37
2/23/70	259	19.21
2/27/70	305	19.38
3/23/70	338	19.23
4/27/70	354	19.52

Only two centers for methadone-assisted withdrawal were available to the addict population of New Bedford. The first was Boston, 60 miles away. Three to five persons would be accepted each week; they were given scrip for dolophine tablets at each of three weekly visits. This method does not work because some pills wind up in the black market or are not used as intended. The second was the Bridgewater Correctional Institute, requiring civil commitment for 14 days. Few would go to a prison setting for help, especially since many were former inmates and on parole or probation. The need was for a community facility.

ESTABLISHING A CLINIC

The medical staff of St. Luke's Hospital was challenged with the need for treatment of the heroin addict. They responded by questioning the Mental Health Clinic regarding their ability to provide ongoing treatment of addicts who had been detoxified. Mental Health stated they could adequately rehabilitate the detoxified heroin addict over a long period of time. (This statement proved to be over-confidence on the part of the Mental Health, as the case load climbed from 80 in December, 1969, to over 356 by April 27, 1970, with no addition to existing staff). Therefore, this challenge of medical treatment, primarily detoxification of the addict, was presented to the staff of St. Luke's Hospital. A committee was appointed by the staff to investigate the treatment of the heroin addict and to report whether or not there was a need for this treatment in the community.

After appropriate study, the committee concluded that a detoxification treatment center or clinic was indeed essential. This information was transmitted to the administration of the hospital who, after discussing the problem with the trustees, accepted the recommendation of the medical staff committee.

On December 16, 1969, the detoxification clinic opened. It was possible to do this only because of the complete community hospital cooperation in organizing the detailed administrative and treatment aspects of the heroin addiction problem. In conjunction with the medical staff, the entire forces of the department of pharmacology, hospital nursing services, administration, and finances were mobilized to attack the problem.

An Advisory Committee was formulated, composed of the director of the detoxification clinic, director of nursing services, clinic supervisor, a member of the welfare department, the emergency room physician and his nurse, the director of the drug dependency unit, the executive director of New Bedford Mental Health, the chief pharmacist, the director of Aid for Addicts, and a minister who is director of a church drop-in center. This committee meets every other week.

In addition, a case review committee was established which meets twice weekly if necessary. This committee consists of the director and associate director of the detoxification clinic, the director of the drug dependency unit, a social worker, the director of Aid for Addicts, and the clinic supervisor. *All* cases for readmission are reviewed and the problems of the individual patient discussed. After adequate repeat courses and repeated reviews, some cases are not permitted to return. Those are candidates for methadone maintenance. There are five at present and at this time there is no maintenance program.

Efforts have been made to have the Mental Health Clinic purchase services from St. Luke's Hospital Detoxification Clinic. It seems unwise to have Mental Health duplicate the established and ongoing services of an excellent community hospital. This could come about if the State Legislature appropriates money for the Department of Mental Health to use for this purpose.

THE OPERATION

There are four physicians working in the Detoxification Clinic. Two work three hours a week; one works two hours a week; and the Director works four hours a week.

The selection and intake of cases including history of drug use, social history, etc., are done by the Mental Health Clinic and the Aid for Addicts (See Table 3).

Note: 44% of these addicts started on heroin without any other drug. Unfortunately, prior alcohol use was not recorded. All private referral and emergency walk-in cases are referred to either of these groups for screening, evaluation and recommendations.

Four days a week the patients talk with a physician. Orders are written and carried out by the nursing personnel. No prescriptions are given to the patient. Methadone in solution mixed with cranberry juice and a sugar additive is taken in the presence of the doctor or clinic nurse.

The addict must be motivated to come to the clinic one, two, or three times a day, depending on his written orders. Failure to appear could

TABLE 3.—*Drug history from first drug use to use of heroin.*

	AGE DRUG FIRST USED—TYPE OF DRUG				
CASE NO.	Glue	Pills	Marijuana	Speed	Heroin
1	10		14	16	17
2			14		18
3				16	16
4	10				17
5					17
6	13		15	17	20
7		12	17	17	18
8			15		17
9				17	18
10			15	15	17
11			18	19	20
12			18		21
13			16		20
14			17		18
15					16
16					17
17	17				20
18			17	18	20
19					18
20			14		16
21				17	18
22				18	19
23					19
24					19
25					19
26					19
27					19
28					19
29					20
30					22
31					22
32					22
33					22
34				21	22
35			17		18
36			15	17	18
37			18	18	19
38			9		14
39					16
40		12	12		16
41			16	19	21
42					17
43			15		17
44			17	18	19
45					16
46					15
47					15
48					15
49			16		17
50				14	17

result in a review of his case and possible suspension. Chloral hydrate is used almost exclusively to assist sleeping if neeessary during the initial days of treatment.

As the dose of methadone is deereased, the patient is uneasy, uneertain, jittery, "spaeed out" and tempted to "shoot up." This usually oeeurs as the dose drops below 40 mg of methadone a day. To eombat this problem, either diazepam (Valium) or hydroxyzine (Atarax) is preseribed, and eounseling and psyehotherapy intensified. Considerable therapy is possible because the physician talks with the patient at least four times a week.

Each patient routinely reeeives a complete physieal examination, ehest x-ray, tuberculin test, urinalysis, eomplete blood count, and any other test which is indicated. He also is given medieation required to treat any illness or physical complaint he may have.

Arrangements have been made with the hospital seeurity and loeal police to stay outside the Detoxification Clinic area. Patients are informed that if they are questioned in the hospital outside the Clinie area, they must have adequate reason for being there or aeeept responsibility for the outcome. The local and state police have been most eooperative and eonfine their activities outside of the immediate hospital area of the Clinic.

The direetor of hospital nursing services has organized an in-service training program for the hospital personnel and others interested in the problem. The program director has lectured to the hospital security and local police orienting them to the nature and scope of the problem.

Any patient not abiding by the rules and regulations of the program is referred back to Mental Health or Aid for Addiets for additional evaluation and commitments. If these seem adequate to the Clinie personnel, readmission to the Detoxifieation Clinie is allowed after the addict meets with the ease review committee.

The demands on the Clinic have been so great that the daily number of addiets may have to be limited. The addiets know that if they do not meet the limits set by the Clinic, they can be dropped and their place taken by someone who is willing to aecept these limits. The addict's respeet for the program inereases when he realizes that the reasonable rules and regulations of the program are enforeed.

In detoxification the patient is free of heroin in less than 72 hours, and after he is *slowly* withdrawn from methadone, he is faced with a rehabilitation problem of one to three years or more.

OBSERVATIONS

On Deeember 19, 1969, Dr. John Pepi, who had had extensive experience with heroin addiction at the Correetional Institute on Deer Island for twenty years, advised the Committee on Mental Health of the Massaehusetts Medical Society that the best treatment for heroin addietion was inpatient surveillance for at least one year. From

the experience in New Bedford it was possible to tell the same committee in January, 1970, how impractical it would be to develop a program conforming to Dr. Pepi's recommendation. At that time there were records of 185 known addicts in New Bedford. How could one have an institution for the treatment of so many heroin addicts? (The number of heroin addicts on February 27, 1970, was recorded as 307). The unrealism of this approach to the problem seems obvious if the potential of the number of heroin addicts in the State approaches the number of addicts in New Bedford.

By January 18, 1970, 48 addicts had been treated at the Clinic. Subsequent dates of review and the status of the first 100 cases are listed in Table 4. In this article "clean" means living a drug-free existence as far as history and outward evidence of drug use are concerned. It does *not* mean cured. It is *not* supported by urine tests, for they are not available. Note in Table 4 the decrease in percentage of "clean" cases from January 18 to May 25.

On May 25 the number of days the 28 cases in Table 4 had been "clean" are given in Table 5.

TABLE 4.—*Review and current status of first 100 cases treated.*

CURRENT STATUS OF CASES	NUMBER OF CASES REVIEWED					
	1/18	2/1	2/22	2/22	3/29	5/25
Clean all the way	20	9	7	21	22	15
Clean 2nd course	0	7	7	9	10	11
Clean 3rd course	0	2	4	4	5	2
Clean 4th course	—	—	—	—	1	0
Subtotal	20	18	18	34	38	28
Dirty on program	6	3	1	3	3	2
Dirty off program	17	18	22	25	37	41
Unknown	—	4	3	4	14	16
Jail	4	4	3	4	3	13
Boston	1	1	1	1	1	—
TOTAL CASES	48	48	48	71	96	100

It was obvious immediately that short-term methadone-assisted withdrawal was not ideal, confirming the opinions of others who had used this method. It was also obvious immediately that our initial dose of methadone was too small. Daily dosage of 40 mg was borderline in adequacy. The dose of 50-60 mg was adequate to cover the symptoms of withdrawal in the small to moderate user, but the heavy user was apt to require a much higher initial dose.

The Mental Health rehabilitation program has improved steadily since the program started but still is inadequate for the needs. In ten weeks' time there were more than 71 heroin addicts under treatment, all requiring a Mental Health follow-up care projection of many months. It is impossible to expect that an already overtaxed, understaffed, and underfinanced Mental Health program could take on all this additional load in an ideal manner.

TABLE 5.—*Length of time patients have been "clean."*

DAYS PATIENT "CLEAN"	ADDICT CASES
156	1
150	1
147	1
132	1
131	1*
127	1*
121	1
100	1
100	1*
98	1
95	1
85	1
82	1*
70	1*
63	1
58	1
56	1
44	1*
43	1
32	1*
27	1
26	1*
19	1*
17	1
Patients on Active Treatment	4+
TOTAL CASES	28

Clean after 1st course	15
* Clean after 2nd course	9
+ Clean on 2nd course	2
+ Clean on 3rd course	2

The case review committee has been hospital-oriented. Through experience it has become important to consider this committee as a mental health effort since the Detoxification Clinic depends so heavily on their recommendations.

There are no facilities in this program for the testing of urines for opiates, methadone, quinine, barbiturates, or amphetamines. We feel that an ideal program should have urinalysis available. However, the short-term methadone-assisted withdrawal program of 10 to 14 days actually does not need urine testing because the course is finished by the time urine reports might be available.

The short-term program was changed rapidly to a minimum of three weeks with a recommendation that a more prolonged methadone-assisted withdrawal program should be developed. This would require proper urine testing. Repeated failures on this program might then be considered

for a methadone maintenance program. We feel it is important not to give adolescent addicts methadone maintenance unless they have had relapses following attempts to kick "cold turkey," or following a short-term or prolonged assisted methadone withdrawal regimen. These withdrawal attempts must be in conjunction with a closely structured mental health rehabilitation program which should be even more demanding if failures occurred. This information, along with the number of arrests, jail sentences, length of time on heroin, home problems, etc., is very important to study before methadone maintenance is recommended.

LEGISLATION

An organized effort to review legislation and recommend new laws or changes should be made. Requiring parental consent for treatment by a physician or in a hospital is outdated. Reporting of addicts by name is bad. Inclusion of marijuana under narcotic laws is false, and the kids know this. So do you. Is marijuana a narcotic? No!

There should be a differentiation between a drug user, selling drugs to support his habit, and a "pusher," in it for profit only.

The "first-offender" concept should be changed. Most first offenders still think drugs are "cool," and have not seriously thought of change. All persons, regardless of prior convictions, should be afforded rehabilitation rather than incarceration.

COMMUNITY INVOLVEMENT

The week ending April 18, 1970 terminated an appeal to the community for funds via a telethon which netted more than $150,000. This money is being used to support the Mental Health program but not the detoxification program.

RECOMMENDATIONS

1. St. Luke's Hospital should continue this program.
2. An increased, structured mental health program is desirable.
3. Urine tests should be available for a prolonged methadone withdrawal and maintenance program. (They are expensive and difficult to obtain in Massachusetts).
4. The Department of Mental Health should purchase services from the Community Hospital. A mental health clinic should *not* take over these services.
5. Legislative changes:
 a. Abolish the requirement of parental consent by the doctor. Parental consent for the treatment of a patient with gonorrhea or syphilis is no longer required.
 b. Abolish the requirement of parental consent for the treatment of a minor in a hospital, mental health clinic or physician's office.
 c. Report addicts to Health Department by number rather than by name.
 d. Differentiate between a drug user selling drugs to support his habit, and a person in it for profit only.
 e. Change the first-offender concept. Most first offenders think drugs are still "cool," and have not seriously thought of change. All persons regardless of prior convictions should be allowed to receive rehabilitation rather than incarceration.
6. Improve statistical studies and develop a sound evaluation of the program.
7. Continue taking history of previous alcohol use by the addict.
8. Methadone in solution in cranberry juice with sugar additive has a marked acidity, is palatable, and seems to produce fewer allergic skin reactions than a vehicle with an orange flavor.
9. Additional supporting units to the Detoxification Clinic, ie, Half Way House.

CONCLUSIONS

1. The community hospital is a logical place for a detoxification clinic.
2. Other detoxification clinics should be established and at this time confined to larger cities with populations of at least 100,000. With this criterion, only four would be developed in Massachusetts outside of the Greater Boston area.

ADDENDA

As of July 28, 1970, the following can be reported:

1. Money had been appropriated by the Commonwealth of Massachusetts for the Department of Mental Health to purchase from St. Luke's Hospital services essential for the detoxification of an addict.
2. Changes in the consent law for treatment of the addict have passed the House and are being considered by the Senate.
3. Alcohol was the first drug used by 85-90 percent of more recent cases.

226 N. Kuakini Street, Honolulu, Hawaii 96817.



CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 312, Camden, New Jersey 08101.

There's a soup for almost every patient and diet ..for every meal and, it's made by Campbell

Editorial

Straub Clinic, Inc. - Fiftieth Anniversary Year

I was already here, in 1921, when The Clinic, as it was then called, was born. I was a small boy, with my brother and my parents, refugees from the anarchy that had overwhelmed Russia at the close of World War I.

The Americans were over there. They had an expeditionary force together with the British in Archangel, an arctic sea port in Russia. Americans fought and died on Russian soil with vague intentions of pressing southward toward Moscow to carry out Winston Churchill's private dream of "snuffing out the life of the infant Communist Bolshevik in his cradle." The Americans also had an expeditionary force in Siberia, together with the British and Japanese and others "to keep open the trans-Siberian Railway" in order that the Czechs retreating from the Eastern Front could be rescued and brought out via Vladivostok on the sea of Japan and around to fight the Germans on the Western Front once more. General Graves, USA, commanding in Siberia, tried to be non-partisan between Bolsheviks and Czarist White Russians, however. The American Red Cross Relief organization under Hawaii's Riley Allen went inland as far as Omsk, some 3,000 miles into the heart of Russia, to care for the refugees along the railway. Omsk had a thousand-bed hospital run by a medical staff of the A.R.C. and the physician in charge was Arthur Jackson, MD, later to become one of the original five of The Clinic.

President Woodrow Wilson had the courage and the wisdom not vouchsafed to some of our modern leaders; he ordered the complete withdrawal of American forces from an un-win-able situation in spite of national cries of "for shame." And it was through the encouragement of Dr. Jackson that Dr. C. F. Reppun and his family, refugees in Omsk and working at the hospital, got out of Siberia with the last echelon of the A.R.C. and settled in Hawaii in 1920.

I remember the strange architecture of the olive-brown two-story building on Beretania Street—somewhere near Miller Street, I think. It was of wood, rather ornate, the second floor overhanging the first. The nameplate read: Straub, Jackson, Milnor, Fennel & Clarke, MD's, not necessarily in that order.

My father was not associated with The Clinic, but he always had a high regard for its members, their work, and their sense of continuing education through research. Naturally, he and his family were its patients too.

When I returned to the Islands as a young physician myself, it was after my father had died, and after I had served my adopted country in World War II. My father had served *his* "adopted" country as a physician in the Russian Czar's army —he was not a Russian himself (and my mother never in her heart gave up being a Britisher!)— so I was following a similar pattern of life as it were, each one of us deeply involved in a World War. With a young family, I chose to practice plantation medicine on Lanai, as he had chosen the Ural Mountains and a small mining town and hospital in his day.

The Straub Clinic (the new name adopted in 1952) was my medical home base during the ten years I was on Lanai and Molokai. Its specialists were always ready, willing, and able to help when help was sometimes desperately needed by a young know-nothing practitioner out in the sticks. Dr. Bowles used to give me calm, wise counsel over the phone between my delivering twin A and an obstreperous twin B; he would come over by first available canoe or private plane when I needed him right there. Pat Burgess often came to my rescue; Warren White used to hold clinics; Bill Hartwell could calm anybody's nerves with his relaxed and assured manner. These are just to name a few. On the rare occasions of my visiting the "big city," I would be invited to share a brown bag lunch and then listen avidly—like one starved —to case presentations at The Clinic. It was a great outfit, with a pervading sense of medical

HAWAII MEDICAL JOURNAL

assistance to colleagues. It had a special rapport with us distantly isolated outer-island plantation physicians. Our TAPP annual meetings on Maui, Hawaii, Kauai, and even once on little Molokai, were always well attended by the "greats" from Straub—who came not only by invitation to teach but also to appreciate at first hand our medical tribulations, and to have a good time with us.

In the last fifteen years, since we moved to Oahu, the overall picture has changed beyond recognition. Both people and doctors have moved into Hawaii *en masse*. The many tall buildings that are so new are simply an expression of these changes that seem to have come with statehood. The Straub Clinic has reflected that change by itself growing tremendously in size and capacity. Nevertheless, it is no longer the big frog in a little pond.

From where I now sit in my office twelve miles across the Koolaus, in a still-suburban town, with our own small medical community centered about a nice hospital that is just about to double its size, Honolulu proper appears as a metropolis full of medical practitioners, solo and in groups large and small, every hospital expanding rapidly. At the county medical society meetings, so many new physicians are introduced each time that the sense of the "old village" is totally gone. The Straub Clinic is just another facility across the hill—or is it? The medical set-up on Lanai is now a part of Straub—an outreach. But so does Kaiser have outreach facilities, and many more than one. It will soon be the "Straub Clinic and Hospital," with emergency facilities staffed around the clock. But Kaiser has had that for several years. Queen's will probably soon have an office-hospital complex, and so will Kuakini, no doubt.

I have often wondered whether Straub would go the way of the Mayo Clinic—accepting only patients referred by outside physicians. It could have become a faculty of consultant-specialists. But it hasn't. It has always accepted walk-ins, even though it had no generalists to screen and medically manage such patients; it has chosen to build a competitive structure—competitive with solo practitioners and other groups. It has catered to those patients who like to pre-diagnose their own ailments and head directly for their ophthalmologist O.S. (left eye specialist!). As it has grown in size, the competitive spirit naturally has had to be emphasized the more; the higher the overhead, the less can an institution afford to dispense free good will and charity. There are many practitioners in this community who are resentful and touchy about the new Straub, therefore.

Too bad, if that is so. We who have grown up with The Clinic cannot easily accept this attitude or feeling on the part of the *koleas*. We still look upon Straub as **The** Clinic—one to which we can safely refer a patient, get a prompt report of a thorough work-up, and have the patient sent back to us once the expert services, whether diagnostic or therapeutic, are completed. We hope that size does not become synonymous with either an impersonal attitude or a "quick once-over," to the disappointment of the referring physician and to the detriment of the patient.

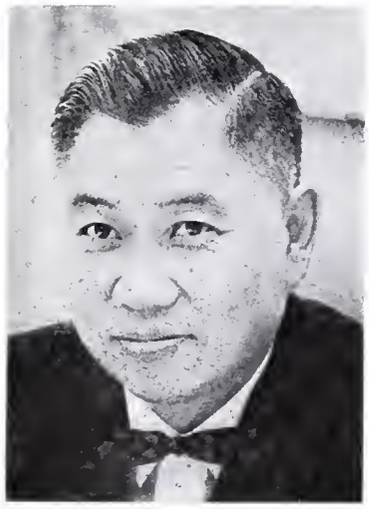
We extend best wishes to the Straub Clinic on its fiftieth anniversary—fifty years of service of the highest order to the community, to hundreds of thousands of patients, and to us its colleagues. We wish it continuing success in these endeavors as it embarks upon new ventures!

As one who has been on the outside looking in for close to fifty years, father and son; as one whose recollection of a debt to Arthur Jackson, MD, will never fade; as one who has always considered The Clinic to be revered as my preceptor in 25 years of general practice, I would like to extend a personal Aloha.

The Clinic's "old" men were great and still are; may its "young" men follow in revered footsteps. To Straub, Jackson, Milnor, Fennel, Clarke *et al* . . .

Mahalo!

J. I. Frederick Reppun, M.D.



The President's Page

Your Hawaii Medical Association recently had a joint meeting with representatives from concerned hospitals and the University of Hawaii Medical School regarding integration of facilities and staff. If the four-year medical school is to be a fact, we can no longer accept the separation of the medical school from community hospitals. To do otherwise would be to subscribe to unjustified costs with a narrowing of available material, and not preparing doctors for the actual setting in which the majority of them will be practicing.

The medical school should increase its scope in education to include internship and residency programs. However, a long hard look should be taken regarding the financing of interns and residents, since we are wholly committed to their continuing education. Also, the medical school must become acquainted, if not involved, with all types of delivery of health care.

The Hawaii Medical Association in its study of medical care in this community, hospitals with their willingness to integrate with the medical school, and the medical school with a four-year program in its sights, have the greatest opportunity in these 50 States to lead the Union towards a new concept of medical education and health care.

Certainly, not even the federal government can afford overall unrestricted medical care. The difficult problem is defining quality care and defining optimal, acceptable, or other such terms, as they relate to medical services.

Some of these problems may be answerable at the completion of the Hawaii Medical Association's quality of health care study. Here again, the Chamber of Commerce has come through with $5,000 to initiate the cost of care study. Others, such as HMSA and Aetna Life Insurance Company, have expressed interest. We, as physicians, are getting an exceptional opportunity to determine our destiny by participating as members of EMCRO, or at the seminars held following the first and second phases of the study. If we do not attempt to call the shots based on actual studies, others will do it for us.

Herbert Y. H. Chinn

Slants and Angles

HAWAII MEDICAL JOURNAL

Dolls, Dogs, and Diagnosis

In ancient China it was considered unseemly and improper for any male physician to examine the naked body of a lady of high social rank. To spare both doctor and patient from such embarrassment, a small, exquisitely carved ivory doll was used as a diagnostic tool. On arriving at the bedside, the doll would be handed to the sickly socialite, who would indicate by pointing or charcoal marks where the trouble was situated. The doll was then handed back to the physician, who, hopefully, was able to make the correct diagnosis.

Amusing as this ritual may seem, it is perhaps not too far removed from the situation in many of our great medical centers of today, where the physician stays literally at arm's length from his patient while myriads of complicated and very expensive tests are performed to try and establish the diagnosis. Finally, when all else fails, the doctor is at last forced to talk to and actually examine the hapless sufferer. Happily, this last desperate move usually reveals the diagnosis, to the great relief of all concerned.

Now a new twist has been suggested by D. J. Mulder of Amsterdam, who writes (*Lancet,* September 4, 1971).

> "Some physicians claim they can smell certain diseases. Most doctors, however, are unable to acquire a good nose, even after intensive training, so why should they not look beyond their own noses? Most scents perceptible to man, a dog can smell at a thousandth or even a millionth the concentration. Dogs can detect and identify odors which human beings cannot smell at all. I suggest that the low scent threshold and great osmic memory of dogs could be used in medicine. They could be trained to detect the abnormal metabolites (in sweat, blood, urine and plasma) known to be excreted in different disorders. They might also detect other diseases, for example schizophrenia, in which the composition of the abnormal metabolites is unknown. Screening by dogs would indicate the diseases in which further biochemical research is likely to be profitable. For some purposes it might be more convenient to use cheaper macrosmotic animals, such as eels."

Perhaps the more intelligent dogs could be trained to make house calls and take over as physicians' assistants. A kennel in every consulting room may be the wave of the future.

Population Explosion?

Dr. George Ehni of Houston (*New Eng J Med,* September 16, 1971) is intrigued by the mysterious workings of the bureaucratic mind. He writes of "my first encounter with another aspect of medical bigness—a demand from a hospital pharmacy that I supply my new drug control number, which is composed of three alphabetic letters and six digits. This causes me to wonder, and impels me to ask, whether other physicians may not have wondered also why in the world it is necessary for the Federal bureaucracy to employ a system capable of giving numbers to 17,576,000,000 licensed dispensers of drugs when there are less than 300,000 physicians and only a few more than 200,000,000 people in the whole United States."

No comment!

Pagophagia

Pagophagia is a form of pica in which the patient has an uncontrollable urge to eat large quantities of ice. Frequent visits to the refrigerator ice tray are characteristic and the unfortunate sufferer, usually a woman, may even be compelled to carry a container of chipped ice around in order to immediately satisfy her bizarre craving.

When confronted with a case, the alert clinician does not dismiss it as some peculiar psychological aberration. Instead he orders a blood count. This almost always reveals iron deficiency anemia. Correction of the anemia cures the excessive ice-eating.

Pagophagia may, therefore, be an initial manifestation of anemia secondary to heavy menstrual flows, bleeding ulcers or an occult gastrointestinal neoplasm. How an iron deficiency anemia can produce this compulsive urge to eat ice is not known.

W. Philip Jones, M.D.

Inside HMA

HAWAII MEDICAL JOURNAL

Tell It Like It Is

. . . **Communicable Diseases** has been discussing the VD problem. Gonorrhea has been increasing rapidly and is now far and away the biggest communicable disease problem in Hawaii, as in the Nation. Dr. Milton Trager has been spending time pointing out the great importance of reaching asymptomatic cases in the 15-24 age girls. All the doctors need to cooperate, probably doing pelvics and smears on all routine cases in this age group. Dr. Hirschy reports that the Public Health Service is recommending the termination of routine smallpox vaccinations in that some deaths are resulting from vaccination and none from the disease.

. . . **Bureau of Research and Planning** had an interesting discussion on "why the low income consumer groups feel the way they do about the medical profession," and what can be done to educate both groups into better understanding. The pressure is on to establish HMO's, stimulating doctors to form Kaiser-type medical groups for giving medical care.

. . . **Diabetes** is considering a weekly detection clinic to be financed and partially run by the Lions Club at the Queen Emma Clinic on Saturday. This is not to take the place of the Annual Detection Week or of any other clinic or doctor's office, but to supplement all of these, for diagnosis only. Cases found will be referred to their own physicians or other clinics for treatment. Sounds like a good idea. The report on the various methods and meanings of blood sugar analysis indicates that the matter of diagnosing diabetes is much more complicated than it used to be. Read up on it.

. . . **Health Manpower** is recommending that a non-governmental body be established to certify physician's assistants. As of July 1970 there were 2,498 educational programs which had been accredited by the HMA, but only 2 groups (orthopedic surgeons and urologists) have developed job descriptions for these personnel.

. . . The **Ad Hoc Committee** reports on the progress on the 1975 AMA Clinical Meeting to be held in Hawaii. Headquarters are to be at the Sheraton-Waikiki with Hilton Hawaiian Village to be used for exhibits and scientific meetings.

. . . **Environmental Health** has been having long meetings to acquaint themselves with the feelings of various groups and with the bills being introduced by Senator Kenneth Brown, chairman of the *Ecology and Environment Committee* of the State Senate. There will be a lot of bills in the coming legislature on which HMA must take a stand. It was suggested that doctors in public view, particularly those on television, refrain from smoking and otherwise cooperate in the program.

. . . **Public Relations** studied the problem of double telephone listings for physicians who have incorporated. If you do decide to incorporate, I suggest you contact HMA regarding proper listings in the phone book. In response to a physician's question, it was the feeling of the committee that a doctor may appear as a physician in his own specialty on television, as long as he does not have credit listings other than as a technical advisor.

. . . **Community Health** reported on a new modular office building which is supposed to save ½ to ⅓ in building an office building. If interested, contact Dr. Caver. Dr. Lee asks why our State has to establish HMO's, if one of the principles is to decrease hospitalization, when Hawaii already has one of the lowest hospitalizations in the Nation.

. . . Several other Committees met, but I won't bore you with routine details but just say "Mahalo" to **Disaster, TV-Radio, Hospital,** and **Filipino Speakers.**

Aloha.

JOHN BROWN, M.D.

Hawaii Academy of General Practice

. . . Who Takes Care of the "Well"?

Much has been promised as an attribute of HMO's (Health Maintenance Organizations), specifically in terms of preventicare.

HEW's "White Paper" of May 1971 cites "available research studies" as showing "HMO members are more likely than other population groups to receive such preventive measures as general checkups and prenatal care. . . ."

Or, as is often repeated, the following statement complains: "To many people, the incentives in the traditional health care delivery system seem backwards. The physician is paid only when his patient is sick, so there is no pressure for either physician or patient to use earlier services to prevent disease and illness."

The awesome power of the Federal government in the shape of the Administration and its Department of Health, Education and Welfare is behind the arguments favoring the establishment and the expansion of HMO's. Only the deliberations in the Congress stand between us, the people, and this bureaucratic power. We can challenge the Administration's arguments; we can wield power also, but it must be through our elected representatives in the Congress. It is important, therefore, that they hear from us individually and collectively.

Having this in mind, we attempted to garner some facts in a small way at the private doctor's office level, to try to disprove the aspersion cast: That the physician is paid only when his patient is sick.

This 3-month sampling from a general practitioner's office points out that only about 60% of patient visits comprise "episodic" care. The other 40% fit well into health maintenance or preventicare. Is there any doubt that we physicians are indeed concerned with keeping people well? True, we are available and ready for the care of acute illness and injury, the incidence and etiology of which is not of our making and is largely beyond our control, but a considerable portion of "traditional health care delivery" is obviously geared towards keeping the sick from getting sicker. The fact is, a truly "well" person is about as common as a full-blooded Hawaiian, which is to say, with impunity, that every last one of us has some measure of physical or mental disability within us.

Therefore, to say that solo practitioners and fee-for-service groups ignore people NOT acutely ill, is a falsehood; as an argument for the establishment of HMO's it should be scrapped and buried once and for all.

On the contrary, a good argument could be made for the over-emphasis on immunization and health screening, on general checkups, etc. resulting in overwhelming any system of medical care, to the detriment of maintaining the health of the sick, ie, most of the people of the United States!

J. I. Frederick Reppun, M.D.

Table 1.

1971 Period	Office Days	Office Calls HM	AI	FU	Pn	Total	ER	Home
10 Jul - 6 Aug	18½	183	141	92	19	435	4	0
7 Aug - 3 Sep	18½	178	184	115	15	492	5	5
4 Sep - 1 Oct	16	120	168	131	17	436	2	2
Totals	53	481	493	338	51	1363	11	7

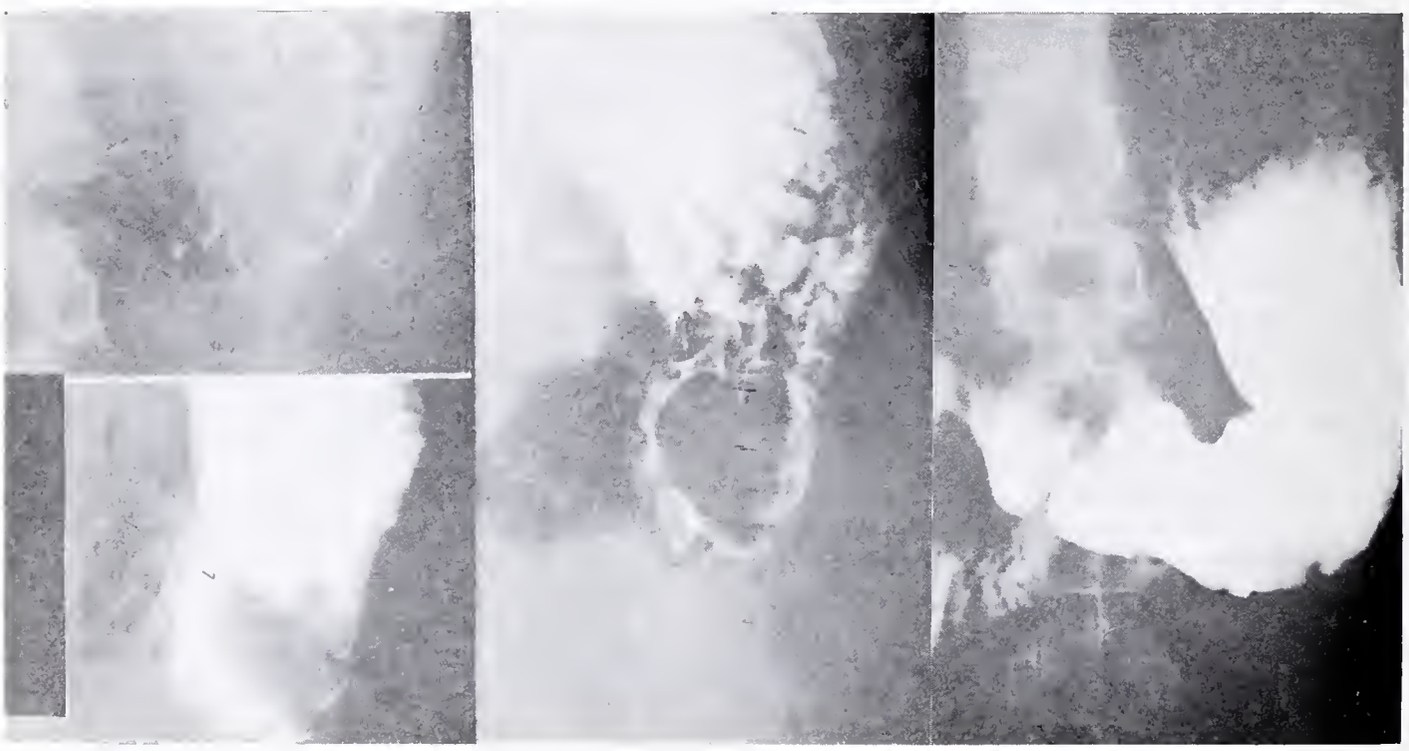
Legend: HM = Health Maintenance = patients with chronic hypertension, diabetes; annual physical exams; well-baby checks and school physicals, etc. (excluded from the count are football physicals done in the field, and separate non-MD visits to the office for immunizations); AI = Acute new illnesses or first visits on both new or old patients for specific complaints; injuries, etc.; FU = follow-up visits on acute illnesses & injuries; Pn = prenatal and postnatal visits in maternity cases—we considered these separate from but associated with health maintenance in reality (actual deliveries were not included in this tally, since they occurred in-hospital); ER = acute illness and injury seen in the hospital Emergency Room, actually AI but not in the office; Home = home visits, also in the AI category.

HM + Pn = 532 = 39% of the 1363 total office visits. AI + FU + ER + Home = 849 = 62% of 1381 acute illness or injury visits made. The "office day" is a scheduled 6-hour day usually stretched to 8-hours. The usual work week in the office is one of 28-hours, the total work week in office, hospital, etc. is about 63-hours. The above figures indicate an average of 26 office patients per working day.

X-ray View Box

HAWAII MEDICAL JOURNAL

- Complaints of this 24-year-old female bakery clerk were:
 1. Intermittent upper abdominal cramping severe enough to awaken at night.
 2. Symptoms of nine months' duration relieved by frequent eating, milk and antacids causing some weight gain.
- No nausea, vomiting or diarrhea.
- General physical examination unremarkable.
- Upper gastrointestinal examination showed an abnormality in the stomach.
- What is your diagnosis?
- Answer is below.



Gastroscopy revealed a gastric mass lesion which had the appearance of a leiomyoma. Because of the vascular nature of the tumor, biopsy through the endoscope was deemed contraindicated.

At surgery, there was a 2x2 cm soft, submucosal antral tumor with a central dimple from which clear fluid poured. The mass was excised.

The pathologist's diagnosis was heterotopic pancreas in the stomach with overlying chronic mucosal ulceration.

Submitted by

ROBERT G. RIGLER, M.D.
RADIOLOGICAL SOCIETY OF HAWAII

HAWAII MEDICAL JOURNAL

Book Reviews

WINFRED Y. LEE, M.D.

★Theory and Problems of Child Development, 2nd Ed.

By David P. Ausubel, M.D., Ph.D., and Edmund V. Sullivan, Ph.D., 849 pp., $13.75, Grune & Stratton, 1970.

THIS BOOK is an excellent reference for educators, pediatricians, clinical psychologists, psychiatrists, social workers and other persons whose professional work brings them in contact with children. It is primarily intended for graduate students in psychology and education.

There are two chapters on the theoretical aspect of child development and a full chapter on personality development. It is the chapter on the development of language, perceptual and cognitive development and the growth of intelligence that is interesting and informative. Then, also, there are specific aspects of cognitive development like memory, intellectual curosity, concept acquisition and problem solving that are excellent.

A final chapter on physical growth and motor development is included to make the book complete. References are made available for more complete sources.

I certainly recommend this book for pediatricians as a reference source especially in answer to the many psychological questions he must answer in his daily practice.

HENRY L. YIM, M.D.

★Therapeutic Advances in the Practice of Cardiology; the Second Cardiovascular Symposium Sponsored by St. Barnabas Hospital, New York City

By Charles P. Bailey, M.D., A. Gerald Shapiro, M.D., and Seymour Gollub, M.D., 470 pp., $22.50, Grune & Stratton, 1970.

THE TEXT is a compilation of essays, papers and panel discussions presented at The Second Cardiovascular Symposium sponsored by St. Barnabas Hospital, New York City. The subject matter and quality of the presentations vary considerably as can be expected from an array of 58 prominent contributors. Broad categories discussed are: (1) The office practice of cardiology, (2) Surgical treatment of valvular heart disease, (3) Coronary heart disease, (4) The surgical treatment of chronic myocardial ischemia, (5) Progress in medical therapy.

The title is somewhat misleading in that it gives the impression that the material is all new. Actually, subjects as well entrenched as the value of digitalis are discussed at length.

The book is recommended not so much as reference but as a good overall review of cardiology.

A prologue by Dr. John F. Briggs, "The Doctor's Dilemma," is a beautifully written, amusing, and revealing study of the "growth and development" or should I say "growth and decline" of physicians. It has nothing to do with cardiology but deals with the "ages of man," the particular man, the physician. This essay, in itself, makes the book worth picking up.

GEORGE I. NAGAO, M.D.

★ means highly recommended.

★Common Skin Diseases, Diagnosis and Treatment

By Howard T. Behrman, M.D., Theodore A. Labow, M.D., and Jack H. Rozen, M.D., 189 pp., $15.00, Grune & Stratton, 1971.

THE AUTHORS of this "simple, small manual on dermatology" have produced just that! It is for the "student and physician with limited access to a consultant." This reviewer cannot recommend it for the dermatologist's library, but the physician with limited dermatology training will find the color photographs easy to read and comprehensive.

While I might disagree with some of the therapeutic suggestions (penicillin is not helpful for acne, though tetracycline is; smallpox vaccination for Herpes simplex is probably of little or no value; and Actidil and Vitamin B6 will do little for sunburn protection), the book contains many practical therapeutic suggestions. Aspirin is a very good antipruritic; a paint brush is recommended for application of shake lotions; and old sheet rather than gauze is suggested for compressing.

The formulary at the rear, the good illustrations and therapeutics hints make it a valuable addition for the generalist's library.

NORMAN GOLDSTEIN, M.D.

★The Anatomy of Aging in Man and Animals

By Warren Andrew, Ph.D., M.D., 259 pp., $15.00, Grune & Stratton, 1971.

THIS IS A VERITABLE BIBLIOGRAPHY of what's known about aging processes in the animal kingdom. It is obvious that Dr. Andrew has not only done a lot of histological research himself but has also done a tremendous job of reviewing the literature. Here is the work of an expert anatomist, reporting on what the naked and the electronically aided eye has actually seen of cell structures and chronological changes therein.

A boring subject? Well, perhaps, but the book will probably be required as a reference text in most institutions of medical learning and I am sure it will remain pertinent for decades to come. It will be the base for further needed research into a subject that is coming to the fore. The book also contains gems of startling interest.

Who would have dreamed that the lowly one-cell Paramecium, reproducing by binary fission, could be anything but immortal? This is not necessarily so: Clones, the series of generations arising from a single individual, unless "rejuvenated" by conjugation with another cell or by endomixis, do show evidence of senescence—loss of vitality with aging.

The author first reviews the phyla, demonstrating no consistency of findings, however. Some species never stop growing; others reach a maximum size; powers of remarkable regeneration vary; reproductive capacity correlates with growth and development; size and age enter the picture, while over all there is the disruptive factor of mortality the result of an inimical environment—what predators do not seize, the viruses, bacteria and fungi destroy and consume. Research is thereby obstructed. Unbelievably, Man is the longest-lived of the animals, succumbing ultimately to atherosclerosis and emphysema.

continued page 502

Notes and News

HENRY N. YOKOYAMA, M.D.

HAWAII MEDICAL JOURNAL

Professional Moves

We are reminded that this *Year of the Wild Boar* brings a good agricultural crop, plenty of fish and more prosperity . . . It should be a good year for change, and changes galore there have been. Back in September, internist **Shozo Ogawa** opened his office at 2065 South King Street; anesthesiologist **Samuel Lui** returned to the Islands and opened at 1127 11th Avenue; allergist **Ray Allen** joined the Fronk Clinic and former Tripler ballad singer and ENT man **Edwin Dierdorff** opened at the Kailua Professional Center Building. On Kauai, former Honoluluan and HMSA director, **Vernon Waite,** is back and joined the Waimea Clinic when the post of professor of surgery at the U of H Med School met with delays. Internist **Christoff Noll** who hails from Switzerland and who did post grad work at Utah Medical Center also joined the Waimea Clinic. On Maui, OB GYN man **William Hoskinson** joined the Kaiser Medical Care Program. On the mental health front, **Aldon Roat,** medical administrator of the State Hospital succeeded J. Kendall Wallis as executive officer of the State Health Department's Mental Health Division. We also gleaned from the same news item that **Kendall Wallis** "is resigning (for the umpteenth time) to complete a book dealing with his 'way out' theories on the evolution of mental disorders." We are happy to learn that **Audrey Mertz** who left for Alaska is back and working for a Master's Degree in public health at the U of H. With the latest shifts, there are now a total of seven physician positions unfilled in the Health Department. The Department's personnel officer happily notes that there has been an increase in physician applicants, "despite the fact that Hawaii pays at least $5,000 to $10,000 less than the mainland generally . . . Our pay is not competitive, but we rely on more than salaries to attract recruits." (Such as? Then why the vacancies?)

By October, there was a noticeable decline in the stirrings of *Homo Sapiens Medicus.* Radiologist **D. R. Grininger** opened at 1315 South King Street, internist **Melvyn Kaneshiro** joined the Kalihi Medical Center and on the Big Island, internist **A. Scott Miles** joined **R. P. Henderson** at 133 Kinoole Street.

Medically Speaking

The "Cancer in Hawaii" program proved to be one continuous dialogue of wit, humor and information with panelists, **Harry Arnold, Jr., Fred Greenwood, John Keenan,** and **Paul Tamura.** The subject was breast cancer and Fred Greenwood, between puffs on his cigarette, was saying, "If hormones go awry, or askew, this can produce an environment in which breast cancer can develop . . ."

John Keenan, looked disapprovingly at Fred's cigarette and keenly aware of his Cancer Society affiliation remarked, "I would like to go on official record that I do not approve of Dr. Greenwood's smoking . . ."

Fred demurred, "I'm a registered nicotine addict."

Paul Tamura pitched in, "Let's ask Fred if he believes smoking causes lung cancer.'

Fred retorted with mustache bristling: **"Cliff Strachley** (Cancer Society president and Kaiser thoracic surgeon) really hit home for me and **Eddie Sherman** when he said "20-20-20." That's 20 cigarettes a day for 20 years . . . and a 1 chance in 20 of developing lung cancer . . . You know what Eddie Sherman's reaction was? 'That's not bad odds . . .' "

Again, when Harry Arnold reported that there was a nearly 50 fold difference in the incidence of skin cancer between the Japanese and Caucasians in Hawaii, and that skin cancer hardly ever metastasizes, moderator **Gordon Burke,** ever mindful of the listening lay public asked, "Dr. Arnold, you used the term metastasize and did not tell us what it meant . . .' Harry explained, "It means to spread to another part of the body." John Keenan (himself a Scottish immigrant) looked directly at Fred Greenwood and chided: "Yes, like an Englishman coming to Hawaii." Gordon turned to Fred: "Did you metastasize, Fred?" Fred: "Heck no! I was deported . . ."

From Tom Thorson's Corner

A modified Zulu joke: A physician was in Tokyo for a medical convention and stopped at a Ginza bar for a nightcap. The ever helpful hostess seeing the lonely American asked, "I help?" The visitor gratefully opened up: "Listen, I'm a Jew from Brooklyn. If there are any orthodox Jews around, I'd like to buy a round of drinks." The hostess seemed momentarily befuddled, but smiled quickly and said, "Excuse please . . . I ask in back." She returned shortly, bowed reverently and regretfully reported, "So sorry . . . we have orange juice, apple juice, guava juice, pineapple juice, but no orthodox juice . . . You try some other kind juice?"

From Claude Caver's Collections

Two teenagers were openly discussing their problems on an HRT bus . . . "You know, I think I *hapai* . . ." "You tell him already?" "Yeah, I tell him . . ." "What he say?" "Excuse, huh?"

Two local Pollaks decided to go into business . . . They purchased a pickup truck and drove to Waianae every day where they bought papaya from the growers at 25 cents a pound. They would drive back to town where they successfully resold the papaya for 25 cents a pound. After a week of hard work, they added up their assets and much to their chagrin, no profit showed. After some deep thinking, Manuel, the brighter one, concluded, "Next week, we get bigger truck . . ."

Life in These Parts

Even in this day of fashionably dressed men, we feel **Claude Caver** tops them all . . . To a TV committee meeting came Claude bedecked in cranberry red pants with vertical white stripes, royal blue striped shirt and a white polka dot blue scarf to set off his pompadour auburn hair. **Rowlin Lichter,** who is quite a fancy dresser himself sat down next to him, and scrutinized Claude's dress for a full minute through his dark glasses. **Becky Kendro,** our secretary, overheard Rowlin comment: "I'm glad I don't have my regular glasses on . . ."

Mod dresser **Ed Ichiriu** retains a touch of the old with his colorful bow ties. Since the manufacturers seem to have stopped production of those handy clip-ons, and ours were rapidly getting frayed and smudged, we inquired and learned from Ed that Hub's still carries them. Ed also recommends a spray-on Fabric Protector by Scotch Guard and carried by Holiday Mart. Perhaps, we can now stop spraying our remaining ties with Squibb's Rezifilm which stiffens and discolors and should be used for wound dressings as originally intended. Another adherent to bow ties is **Ed Chesne** who cuts quite a striking figure with his brown Freudian beard, snug fitting double knit pants, bright luminescent shirts, and large fluffy polka dot bow ties which he incidentally ties himself . . .

Claude Caver, a B'Hai faither, informs us that there are now 28 B'Hai communities in Hawaii alone and feels that physicians could benefit from its teachings, especially that section that stipulates that one must not self medicate without illness, and when ill, one should attend a physician, and abide strictly by his orders . . . ("A physician who treats himself is by far the biggest fool." . . . Caver *circa 1971*)

Since we were not among the 400 women who attended the October sex session entitled, "Two for the Seesaw of Life" and conducted by the HCMS's Auxiliary, we have extracted liberally from **Pat Hunter's** excellent reporting so that our men folk can be forewarned . . .

"Is it natural for a married man to have nocturnal emissions?" Ob Gyn man **Ralph Hale** replied, "Most men don't have this problem because they find masturbation more satisfactory . . . If a married man is having such emissions, the situation surrounding the problem needs to be explored . . ."

"What about couples who have problems because one or the other partner wants oral sexual stimulation and the other finds the practice disgusting?" Psychiatrist **Charlotte Florine** was vague: "Any sex practice that is comfortable for both partners is all right. But if one partner feels uncomfortable with a particular desire on the part of the other, discussion is needed to reach understanding and agreement about what things both enjoy."

On the subject of women dreaming about men other than their husbands, Charlotte grinned: "I think all women—and men, too—find individuals other than their mates attractive."

"What if your husband is gone for half a year? What do you do about that?" Ob Gyn man **Ron Pion** was quite frank: " 'The Sensuous Woman' and Dr. **David Rubin's** book about sex have given masturbation mass appeal. If you're away from your husband or wife, you've got two choices. You can go to a bar and pick up someone and possibly something . . . Or you can lie in your room and stimulate yourself to orgasm along with loving fantasies about your spouse." (It seems that none of the panelists advised abstinence . . .)

On communication: Charlotte Florine said, "Communications between husbands and wives is most important. They should learn to talk about their likes and dislikes in sexual relations just as they discuss food, fashions, or anything else . . . God made women the talkers of the world, so keep on talking."

On orgasm: Ralph Hale was quite emphatic, "I think that that's another myth finally disposed of. The greatest one ever perpetrated on women—the myth of simultaneous orgasm."

Memo to Cardiac Surgeons

"The way to a man's heart is through his stomach . . . But it's rather messy that way . . ." (Hawaiian Tel joke heard on Aku's program.)

Bernie Fong's latest: "You've heard of the 7th venereal disease?" . . . "Moby Dick . . ."

Medicine and Religion

Tom Maeda had sent an elderly Japanese patient with an abdominal mass to a vascular surgeon for consultation and received the following report: "He noted a mid abdominal mass 3 months ago and claims that after praying in church, the mass has decreased in size . . . I agree that this is an abdominal aneurysm and recommended and discussed surgery with the patient, but he seems to have much faith in his praying in church and prefers to do this in hopes for further improvement in this mass . . . The plan is to have him continue his faith and prayers and if this mass should persist, enlarge or become symptomatic, he will return . . ." (Do we detect an undertone of quiet frustration?)

Daffynitions

George Suzuki says, "An alcoholic is someone you don't like and who drinks more than you do."

Medicare Review Committee

Gourmet **Henry Oyama** whipped off a dozen oysters on the half shell, reviewed his single chart assigned for the month and asked, 'Now, can I order another dozen?" **Ted Tseu** asked incredulously and with a twinge of envy, One chart and 2 dozen oysters? What is the RVS schedule per dozen . . . I understood it was 5 charts per dozen . . ."

Allergist **Allan Young** had a particularly tough dermatology case viz a vitiligo case being treated at weekly intervals with ultraviolet treatments. Being an orthodox allergist and confessing to ignorance, ie, dermatological problems, Allan had made inquiries among the derm men, most of whom felt there was no particular treatment for vitiligo. One skin man had even recommended daily doses of sunlight which, of course, is readily available and would not require weekly visits. The discussion waxed and waned before the pros won with the contention that the office visits probably had beneficial psychological effects . . .

Orthopod and committee chairman **Gabe Ma** was hep on "Lamina Flow" for bone glue cases in which infection was a major factor. There ensued a discussion on the relative incidence of postop infections . . . Cardiac surgeon **Nial Scully** felt that infection was very rare in cardiac surgery. **Henry Oyama** felt that there was less than a 1% incidence in general surgery cases and added that perhaps the abundance of sunlight in Hawaii was a factor. When Ob Gyn man Ted Tseu admitted that the infection rate was about 3% in Gyn surgery, allergist Allan Young gave the forthright explanation: "Of course, you're dealing with a dirty hole . . ."

Sportsmen

Duffers:

The 3rd Annual St. Francis Hospital Golf Tournament was held on two Wednesday afternoons at Mid Pac CC with 33 participants and chaired by last year's winner **Bill Dang.** Handicap chairman **Gabe Ma,** who was out of town, tried to declare the tournament null and void but was outvoted . . . The outcomes were rather surprising since traditional grand slam winner Bill Dang, apparently suffering a Bill Casper slump, came in 8th place. **Al Chun Hoon** who has been shooting some fine golf recently shot 82 and 81 with his 13 handicap to corner both low gross and low net honors, but it was decided to give **Dick Ho** the low gross prize, so third placer, **Ed Kagihara** won 2nd low net and **Calivn Kam** 3rd low net. **Art Salcedo** and **Paul Tamura** came in 8th and 9th respectively . . .

continued page 506

County Society News

HAWAII MEDICAL JOURNAL

Honolulu

The following new members were introduced to the membership at the September 7 meeting: Drs. Robert J. Latta, Elisabeth K. Anderson, Thomas A. Burch, Alistair Philip, Harry Hinson, Leonard S. Kuninobu, Simon Sau-Yan Cheng, Robert C. Hinman, Robert Lewis May, Stanford K. W. Au, Thomas M. Cashman, W. Dawson Durden, Philip D. Hellreich, Hiroshi Ikeda, and Philip I. McNamee.

Speaker for the evening was Mr. Charles "Chuck" Leahey, known as the Golden Voice of Ewa Beach, and presently the 14th Naval District's Director of Special Services. Mr. Leahey's enlightening presentation covered the field of "Sports. . . . From a Spectators Point of View."

An announcement was made of the deaths of several members of the Medical Society: Dr. Edmund L. Lee who died on June 13, 1971, Dr. Harry L. Arnold, Sr., who died on July 25, 1971, and Dr. Robert H. Lee who died on August 16, 1971.

The Chair reported that the Charter and Bylaws Committee has recommended that medical students at the University of Hawaii Medical School be granted the opportunity to become inactive associate members of the HCMS. Following the reading of the amendments as recommended by the committee and approved by the Board of Governors, the Chair stated that these proposed amendments will be circulated in the mail and voted on at the next membership meeting.

Peer Review guidelines for the establishment of a HCMS Peer Review Committee and Subcommittees which had been circulated to the membership were presented for discussion.

Dr. Winfred Lee gave the definition of peer review as being the evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other physicians. Peer review is the all inclusive term for medical review efforts. He stated that examples of peer review efforts that are presently going on include medical practice analysis, inpatient hospital and extended care facilities utilization review committees, medical audit committees, ambulatory care review, and claims review. Dr. Lee reviewed the proposal in its entirety. He pointed out that the committee will not be vested with disciplinary authority. The Peer Review Committee's responsibilities are those of adjudication and its long range purposes should include educational processes designed to improve understanding of the proper use of coverage and services, and hopefully provide mutual benefits to all parties concerned.

Following a discussion of the proposal and the recommendation that the HCMS establish the Peer Review Committee and its subcommittees as outlined in the proposal, a motion was made by Dr. Richard Omura to approve Recommendation #1 as mentioned above. The motion was seconded. Dr. Corboy who objected to the idea of a Peer Review Committee and felt that every physician should be his own peer, moved to table the motion and called for a secret ballot. A secret ballot was taken following which the Chair announced that Dr. Corboy's motion to table did not pass. The motion to accept Recommendation #1 was then voted on and was passed. Further discussion was held on whether the Peer Review Committee should be an appointed or elected committee. Dr. Goebert moved that the part where it says the committee should be an appointed committee should be changed to read that it be an elected committee. The motion was seconded. A motion made by Dr. Sugihara to reconsider Dr. Goebert's motion was voted on but failed to carry. Dr. Goebert's motion that the Peer Review Committee be an elected committee was then voted on and was carried.

New members introduced to the membership at the October 5, 1971 meeting were: Drs. Michael Dang, Gary Glober, Edgar Ho, Roy Kamada, Allan Kunimoto, Fook Chu Li, Samuel Lui, Eugene Matsuyama, Wing Sing Pong, and Eugene G. C. Wong.

The program for the evening included a panel discussion on Estate Planning for Physicians. Panelists were Mr. Joseph Wee, Attorney-at-law, Mr. James, partner, Alexander Grant & Company, and Mr. Robert Hite, Trust Officer, Hawaiian Trust Company. Each panel member presented a talk on a particular phase of estate planning —"Estate Planning in General," and "The Will, Liquidity, and Estate Taxes," and "Trusts and Their Function in Estate Planning." The panel then took three hypothetical cases—young physician, middle-aged physician, and older physician—and discussed estate planning for each.

Dr. Frissell held the second reading of a proposed amendment to the Charter and Bylaws relative to membership in the County Society for students in the School of Medicine, University of Hawaii. It was also announced that the final vote on this amendment will come up at the annual meeting in December.

Dr. William Moore requested that any member with old JAMA copies, please turn them in to him so that he and his wife can include these journals in the packages that are sent overseas.

Dr. William Moore stated that Dr. Marc Shlachter is now practicing in Hauula under the guaranteed income program of the State. The County Society was very instrumental in getting Dr. Shlachter into the area. At present, Dr. Shlachter is in need of additional office equipment, in particular, an examining table. Anyone who has some unneeded office equipment that he would like to donate is asked to contact Dr. Shlachter.

Hawaii

Fourteen members attended a meeting held September 22, at the Hilo Hotel. Mr. James Dunn spoke on the functions of a computer laboratory.

Dr. James Mitchel, Chairman of the Scholarship Committee told the group that his committee had decided that loans be made to prospective medical students with only three percent interest and that the loans would be payable only on graduation. The loan would be cancelled if the applicant returned to Hawaii and practiced for one year. The loan would be payable in $50.00 monthly installments. In the past year, two students have been helped. One at Northwestern and another at San Antonio, Texas. Presently there are two applicants for the medical school at the University of Hawaii requesting assistance.

A change in the Bylaws was discussed, where the library committee would be absorbed by the hospital committee.

continued page 501



Relieves stuffy and runny noses- promptly.
Makes your patient's world a little sunnier.

Triaminic®

phenylpropanolamine hydrochloride, pyrilamine maleate, pheniramine maleate

"the Sunshine Tablet"

Formula: Each timed-release tablet contains phenylpropanolamine hydrochloride, 50 mg.; pyrilamine maleate, 25 mg.; pheniramine maleate, 25 mg. **Indications:** Relief from such symptoms as nasal congestion, profuse nasal discharge and postnasal drip associated with colds, nasal allergies, sinusitis and rhinitis. **Precautions:** Patients should not drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease, or diabetes. **Side Effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Dosage:** Adults—one tablet swallowed whole, in morning, midafternoon and before retiring. **Availability:** In bottles of 100, 250.

Rx ONLY

Dorsey Laboratories, Lincoln, Nebraska, 68501

New Members



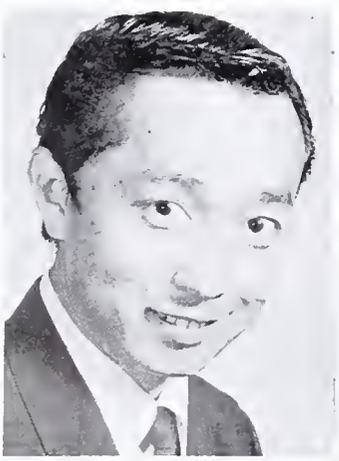
Ben Kamarudin Azman, M.D.
502 Pauoa Street
Lahaina, Maui 96761
GENERAL PRACTICE
University of Alberta, Faculty of Medicine—1968
Internship—Montreal General Hospital—1968-69



John C. Behnke, Jr., M.D.
2180 Main Street
Wailuku, Maui 96793
ORTHOPEDIC SURGERY
University of California, L.A.—1957
Internship—San Francisco General Hospital—1957-1958
Residency—University of California Medical Center
San Francisco—1960-61
All U.C. Affiliated Hospitals—
University of California,
San Francisco—1962.



Michael H. Dang, M.D.
1374 Nuuanu Avenue
Honolulu, Hawaii 96817
GENERAL PRACTICE
University of Colorado—1968
Internship—Santa Clara Valley Medical Center—1968-69



Allan Ryo Kunimoto, M.D.
1481 South King Street, Suite 543
Honolulu, Hawaii 96814
OPHTHALMOLOGY
Northwestern Medical School—1965
Internship—Chicago Wesley Memorial Hospital—1965-66
Residency—LAC-USC Medical Center—1968-71



Fook Chiu Li, M.D.
1374 Nuuanu Avenue
Honolulu, Hawaii 96817
OBSTETRICS-GYNECOLOGY
University of Hong Kong—1965
Internship—Queen Mary Hospital, Hong Kong—1965
Tsan Yuk Hospital,
Hong Kong—1965
Residency—Kapiolani Maternity Hospital—1968-71



Eugene S. Matsuyama, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
INTERNAL MEDICINE
University of Minnesota—1965
Internship—L.A. County General Hospital—1965-66
Residency—L.A. County—
USC Medical Center—1968-71

HAWAII MEDICAL JOURNAL



Gary Alan Glober, M.D.
347 N. Kuakini Street
Honolulu, Hawaii 96817
INTERNAL MEDICINE—
GASTROENTEROLOGY
UCLA School of Medicine—1962
Internship—Wadsworth Veterans
Hospital, Los Angeles—1962-63
Residency—Wadsworth Veterans
Hospital—1963
Mt. Sinai Hospital—1963-64
L.A. Harbor General Hospital
—1964-66
UCLA Medical Center—1966-67
Radcliffe Infirmary, Oxford,
England—1969-70



Edgar C. K. Ho, M.D.
888 South King Street
Honolulu, Hawaii 96813
PEDIATRIC CARDIOLOGY
St. Louis University School of
Medicine, St. Louis, Mo.—1963
Internship—Los Angeles County
General Hospital—1963-64
Residency—Children's Hospital
of Los Angeles—1964-66



Roy O. Kamada, M.D.
888 South King Street
Honolulu, Hawaii 96813
CARDIOLOGY
Washington University,
St. Louis, Mo.—1964
Internship—Cincinnati General
Hospital—1964-65
Residency—St. Luke's Hospital,
St. Louis—1965-66
St. Luke's Hospital—1968-69



Wing Sen Pong, M.D.
86-234 Farrington Highway
Waianae, Hawaii 96792
GENERAL PRACTICE
University of Singapore—1957
Internship—Watts Hospital,
Durham, No. Carolina—1968-69
Residency—Queen's Medical
Center—1969-70
Kuakini Hospital—1970-71



Marc Shlachter, M.D.
P. O. Box 327
Hauula, Hawaii 96717
GENERAL PRACTICE
Cincinnati College of Medicine—1969
Internship—Cincinnati General
Hospital—1969-70
Residency—Kauikeolani Children's
Hospital—1970-71



Eugene G. C. Wong, M.D.
888 South King Street
Honolulu, Hawaii 96813
NEPHROLOGY
Washington University,
St. Louis, Mo.—1965
Internship—St. Luke's Hospital,
St. Louis Mo.—1965-66
Residency—Baylor University College
of Medicine Hospital—1966-67
University of California, L.A.—
1969-70

HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

OFFICERS

President: NOEL D. EVANS, *Vice President:* EDMUND E. EHLKE, *Secretary:* LAUREN WONG, *Treasurer:* MARION CHONG, *Board of Directors:* NELLIE CHANG, WALTER HARANAKA, JAMES MCELHANEY, EARLE SANDISON, HON TING CHEE, BEN CHOCK, WILFRED OGOMORI and BETTY BELL.

PLAUDITS

Plaudits to Dr. Lauren Wong, Seminar Chairman, and Mr. Noel Evans, president of the Hawaii Pharmaceutical Association, and his officers for their meaningful continuing education program.

PAIN, MEDICATION, AND THE PSYCHOLOGY OF PAIN

A portion of the seminar is abstracted for your perusal. Complete tapes of the program may be borrowed by members from the Association Office. (A recorder capable of playing 7" reels at a speed of 1⅞ is required.)

The first presentation was made by Dr. Walter F. Char, Professor of Psychiatry, University of Hawaii School of Medicine, and in private practice, speaking on the

PSYCHOLOGY OF PAIN

What is pain? Pain is an abstract, subjective concept. Pain is one of man's chief concerns in life. Man is always consciously or unconsciously preoccupied with the methods of avoiding or dealing with pain; the concept of the pressure pain principle for instance.

How do we define pain? Not in one brief sentence, for the definition of pain must be approached from many frames of reference.

From the *physiologist's* point of view: pain is a sensation (ie, sight or sound).

From the *biologist's* point of view: pain is a means of survival.

From the *theologian's* point of view: pain is a moralizing force.

From the *existentialists'* point of view: they see the world as a place where *suffering* (pain) is the essence of being human.

From the *philosopher's* point of view: pain is a way of enriching life.

From the *sociologist's* point of view: pain is a tool of society.

Researchers such as Harold and Stewart Wolfe in their book, PAIN, have dealt with pain as a twofold concept.

1) pain threshold—a certain play in which a person will feel pain . . . in brief the pain threshold is the lowest possible level at which a stimulus could be applied (such as heat or cold) and felt. The pain threshold in all people is essentially universal.
2) reaction to pain—Whatever the individual thinks or does constitutes a reaction to pain . . . the reaction to pain is greatly different from one to another and is affected by time and condition.

A physician sees pain as a method to be decoded, interpreted, and acted upon. A pain is a warning of a disease; in some cases, it is the disease itself. The physician sees pain according to his area of expertise, the psychiatrist different than the neurosurgeon.

How a person reacts or perceives any pain, whether of an external or internal stimulus, is highly complex and individualized. Pain is not simply the ability of the body to carry the pain impulse but could well be mental pain . . . as exemplified in the loss of a loved one . . . as opposed to a change in the physical system resulting in *physical pain.*

The element of the human feeling is extremely important in dealing with the whole concept of pain. Example: if you have confidence in your dentist, he will not hurt you etc.

We tend to separate physical pain into two basic types:

1) surface pain—ie, burning finger. The shock of the quality of the pain stimulates the person to do something—pull finger away.
2) deeper visceral pain—ie, stomach-ache. One would withdraw, rest.

Researchers have added other concepts of pain such as having discovered that the pain threshold can be raised 45% by a distracting noise.

Alcohol and tranquilizers can affect the perception of pain; more often they reduce pain by removing the tension causing the pain. Pain is sometimes used as a weapon, a means of negotiation . . . perhaps to get out of a task. Pain is also used as a symbol of valor . . . proof of manhood. Pain, indeed, is an abstract but an interesting concept of the human physic.

Dr. Marvin H. Malone, Professor of Pharmacology, School of Pharmacy Graduate School, University of the Pacific, and current Chairman of the Section on Biological Sciences, American Association of Colleges of Pharmacy Conference of Teachers, presented three lectures, the first of which is abstracted below.

PHARMACOLOGIC APPROACHES FOR THE RELIEF OF PAIN

Ancient man was extremely sophisticated in his utilization of drugs. We find that opium was introduced in Syria in the 7th Century before Christ. The Greeks were using mixtures of henbane, hyoscyamus along with the potions of black magic in very early times. Today we see some of these old atropine-like substances coming back, but supported with a scientific rationale.

Is there such a thing as "pain" as a simple entity? No! The pain of a headache, backache, glaucoma, or angina has its own color and peculiarities. There are several types of pain; therefore, this must mean there are several mechanisms in the body to produce these types of pain.

A quick look at Body Physiology shows that there are three classes of sensory nerves:

1) large medullated nerves: diameter 16-20 microns. A fibers that conduct nerve impulses rapidly 115 Meters/sec.
2) smaller myelinated fibers: diameter 2-5 microns conducting nerve impulses much more slowly 10-20 Meters/sec.
3) unsheathed fibers: diameter under 2 microns conducting nerve impulses even more slowly 0.6-2 Meters/sec.

Ruling out the physiological influences of pain and concentrating just on the physical manifestations, the pain receptors on the *outside* of the body immediately fight back; the pain receptors on the inside of the body (the unmyelinated fibers that conduct very slowly) are connected to the parasympathetic nervous system; for example, if one burns a finger:

1st: flash of pulling hand away is associated with the sensory nerves 2-5 micron diameter.

2nd: the slow burning sensation that follows is related to the unsheathed fibers.
3rd: the actual touch is associated with the big medullated fibers.

There are actually several ways to treat pain:

1) By the local anesthetics . . . that is, to block all nerves affecting paralysis . . . not practical. General anesthetics . . . causing unconsciousness . . . not practical.
2) Anti-inflammatory drugs . . . do not involve the central nervous system in any way; ie, Aspirin, Phenacetin.
3) Drugs that interfere with perception of pain and the feeling of pain . . . ie, Morphine, Meperidine. These drugs activate the hypothalamus and give rise to lots of feelings. They also have potential for addiction.

Analgesics, therefore, represent a whole class of no-receptor agents that stop or tend to block the origination of the pain impulse . . . stopping the pain at its source.

The tranquilizers such as meprobamate and other minor tranquilizers enable a person to feel normal sensations but they are no longer bothered by them. This quality is especially valuable to the physician, for the patient is still able to describe the quality and location of his pain to the physician. Analgesics, on the other hand, should never be used during the period of diagnosis.

At present there are a whole group of sympathomimetic drugs used for "Internal" pain—slow pain of a dull, grinding, burning or nauseous nature. "External" pain—sharp, frightening pains on the contrary respond to a group of sympathetic drugs.

There are other basic groups that inhibit cholinesterase such as the "nerve gases" and prevent pain. The pituitary is akin to the hypothalmus and therefore the anti-stress drugs known as the corticosteroids, an anti-inflammatory agent, seem to prevent the pain of arthritis even though the joints may still be swollen. The group of drugs called hallucinogens alter the perception of pain but has some emotional override.

The above represents briefly the basic groups of drugs utilized for the relief of pain . . . specifics of action and function will be presented in the sections to follow.

Dr. Carl W. Boyer, Jr., Associate Clinical Professor of Radiology, School of Medicine, University of Hawaii, and Director of Professional Services, Radiation Therapy, Queen's Medical Center, spoke on

RADIOTHERAPY

Radiotherapy is mostly involved with the treatment of malignant disease. In 95% of our patients we try to relieve their symptoms . . . only 5% are we able to cure . . . those in the areas of cancer of the larynx, uterus, and Hodgkin's. For the people suffering with the pain of cancer, we try to do something for them rather than to them.

Briefly the presentation was organized into three parts:

1) A short course in Radio Biology.
2) The modalities available for the production of these rather noxious agents that are used.
3) The ways that these modalities are used to treat cancer.

Radio Biology

Light is an electromagnetic vibration . . . the vibrations below visible light represent the frequency (number of vibrations/second) utilized by radio and television. The higher vibrations above visible light are ultra-violet rays, X-rays, Gamma Rays, and Cosmic Rays. These are the rays measured in photons (the measure of electromagnetic energy) that are used in radiotherapy. The basic premise provides for ionization of the atom by knocking the electrons out of orbit by directing the X-ray against a target; literally, radiotherapy is ionizing the atoms in people, producing a whole chain of ions as one knocks out another . . . radiation. Sometimes the electrons are only pushed aside rather than out of orbit; this is known as scatter radiation.

The cell is most sensitive to ionizing radiation just before dividing. Fortunately tumor cells do proliferate more rapidly and are therefore more sensitive to radiation than normal cells. Unfortunately, we cannot destroy tumor tissue without injuring normal tissue; so we have a therapeutic index to divide up the killing dose into several lesser treatments in order to preserve normal tissue.

Modalities Available for the Production of These Noxious Agents

Essentially electrons are accelerated through space, strike a target to produce X-rays.

The first piece of X-ray equipment we utilized was a small *ortho-voltage* machine delivering 100,000-300,000 volts. This equipment is used very little today with the possible exception of skin cancer and benign things.

The second piece of equipment utilized is a *super Voltage X-Ray Machine* several stories high, producing an accelerating potential of two million volts. The higher voltage provides better penetration of the tumor, less skin damage, and very simply, the patients tolerate the treatments better.

Thirdly, we have the *Linear Accelerator,* providing an accelerating potential of (4) four million volts. The machine is one fourth the size of the super voltage machine and works on an altogether different principle. In essence, a big radar tube makes microwaves on which the electrons ride, much like a surfer riding the wave, and then gets shoved against the target. The equipment is simpler, more efficient, and available in units producing up to 32 million volts.

Fourth, the Cobalt Machine, a much smaller unit utilizing radioactive cobalt that absorbs neutrons to revert to nickel, releasing photons equivalent to four million volts. The cobalt source must be replaced about every five years at a cost of some $50,000.

Fifth, a Cesium machine utilizes radioactive cesium that produces a less penetrating ray than the cobalt machine and finds usefulness in the treatment of tumors of the head and neck.

The above generally describes the basic equipment used for external radiation of malignant growths.

Internal radiation is also accomplished and is essentially of two types:

1) interstitial . . . into the tumor tissue
2) intercavity . . . into a body cavity, ie, nasopharynx, uterus.

Radium is a very popular radioactive substance for internal radiation. It is the 7th decay product of Uranium, having a half life of 1650 years. When radium breaks down, we get radon (gas)—isotopes of lead—Radium A—Gamma Rays. The Gamma Rays, the 3-4th decay product of radium, represents the active radiation component of radium, producing an accelerating potential equivalent to a 6-7 MEV X-ray machine. Radium is encased in platinum and gold to absorb the low voltage gamma rays, emitting only the high voltage rays. In essence high concentrations of radiation are presented to confined areas of tumor tissue with minimal normal tissue exposure.

Dr. Boyer very ably demonstrated the utilization of the various modalities presented from preoperative radiation through interstitial radiation utilizing radon and radioactive gold with their respective half-lives of 3.8 and 30 days. The slide presentation of specific application of these modalities to particular tumors and sites was especially interesting but does not lend itself well to abstract description here.

Dr. Boyer indicated that sometimes small doses of X-ray over a long period of time (as may be the case with the acne patient who floats from one physician to another) can cause cancer. It can likewise be cured by high dosages for short periods.

The radiotherapist function is related to the relief of pain . . . always the effects of the radiation is weighed against the benefits to the patient before any course of treatment is prescribed. The collective expertise of the

continued page 503

"I'M FEELING
MUCH BETTER, DOCTOR."

"SO AM I."



HMSA is the "get-well card" that leaves you *both* feeling better. Offers patient and physician lasting relief from medical economic problems. Once again, March, July and November are individual enrollment months. An excellent time to remind unprotected patients about the benefits of belonging to this non-profit community organization. It's good for what ails them. And you.

HMSA

Hawaii-owned for Hawaii's own

HAWAII MEDICAL SERVICE ASSOCIATION

BLUE SHIELD PLAN FOR HAWAII

Member Western Conference of Prepaid Medical Service Plans

HONOLULU: 1504 Kapiolani Blvd., P. O. Box 860, Phone 944-2110
WAILUKU, MAUI: P. O. Box 956, Phone 323-912
LIHUE, KAUAI: P. O. Box 27, Phone 245-3393
HILO, HAWAII: P. O. Box 1356, Phone 935-5441
KAILUA-KONA, HAWAII: P. O. Box 1219, Phone 329-3030

County Society News *continued from 494*

A nominating committee composed of Drs. Batchelder, and Ballerini suggested that Dr. DeWitt Smith be nominated for President; Vice President, Dr. Nagashima; Secretary, Dr. Ballerini and Treasurer, Dr. Allen Takase and the alternate delegates to the HMA meeting would be Drs. Hayashi and Woo. The delegates, Dr. J. Mitchel and Dr. Haruto Okada. The Counsellor, Ed Helms. It was suggested that two new members be added to the malpractice committee.

Twelve members, plus guests attended a meeting of the Hawaii County Medical Society, at the Keauhou Beach Hotel in Kona on October 9, 1971.

Guest speaker was Dr. David Fergusson, Cardiologist from the Straub Clinic in Honolulu, who presented a lecture regarding treatment of acute Myocardial Infarction.

The business portion of the meeting was presented by Dr. Verne Adams and several items of interest were brought up.

The treasurer reported that $2,000.00 has been placed in the scholarship fund. Overall balance is now $3,700.00.

A change of Constitution and Bylaws were approved. The library committee has been changed to the hospital committee.

A meeting will be held at the Hilo Lagoon Hotel on October 19, 1971, and will cover the organization and management of health services in the event of a disaster. Service organizations such as the Police Department, Fire Department, and Civil Defense along with the Hawaii County Medical Society will sponsor the meeting.

The December meeting is expected to take place at the Volcano Country Club. Wives are asked to be guests of the Society.

The following were nominated for positions outlined below:

Dr. Egbert Fell—Delegate to the Hawaii Medical Association; Dr. Peter Fleming—Alternate Delegate; Dr. Keith Nesting—Malpractice Committee; Dr. Thomas Mar—Malpractice Committee.

The following are committee appointments for the Hawaii County Medical Society.

Adjudication.....Thomas M. Mar, M.D.
Bylaws & Parliamentary..Shizuto Mizuire, M.D.
Cancer.....Verne L. Adams, M.D.
Careers.....James E. Mitchel, M.D.
Maternal & Prenatal Mortality Study
Peter A. Fleming, M.D.
Operation Pacific.....R. P. Wipperman, M.D.
Public Relations.....Edward A. Ballerini, M.D.
Water Safety.....Walter S. Loo, M.D.
Indigent Medical Care..James E. Mitchell, M.D.
Japanese Speakers Bureau.....C. Hayashi, M.D.

The regular meeting of the Hawaii County Medical Society was held on Thursday, November 18, 1971, with 11 members in attendance.

The meeting was called to order by president Verne Adams who introduced the principal speaker, Dean Terry Rogers of the University of Hawaii Medical School. The development and goals of the Medical School and their method of function at present was the topic of discussion.

A second speaker, Mr. William Simonsen, Senior Public Health Advisor with the State Department of Health discussed the Rubeola Vaccination Program now in effect in the Hawaiian Islands.

A motion was made and passed that the Hawaii County Medical Society endorse the Health Department's efforts to have children not previously vaccinated for measles (Rubeola), vaccinated. The program is expected to be in conjunction with that of the Education Department on this Island.

A motion was made and passed that the Library Committee of the Hawaii County Medical Society be changed to the Hospital Committee.

A motion was made and passed that the Hawaii County Medical Society go on record endorsing the Hilo Hospital Utilization Committee to incorporate the reviewing physicians for the Kohala and Pahala districts as a member of its (Hilo Hospitals) Utilization Committee.

It was decided that the annual Christmas dinner be held at the Yacht Club. Arrangements will be made.

Dr. Edward Helms, who attended the council meeting of the Hawaii Medical Association, revealed highlights of that meeting to those present. He suggested that better communications be established between the Hawaii County Medical Society and the State Medical Association.

FRANCIS F. C. WONG, M.D. 1919-1971

On September 16, 1971, death came to Dr. Francis F. C. Wong after a prolonged and painful illness. He will be missed.

Dr. Wong was born on February 28, 1919, in Pahala, Hawaii, to the late Mr. and Mrs. Share Kim Wong. Dr. Wong graduated from Hilo High School in 1936 and received his BA from the University of Hawaii in 1940. He attended medical school at St. Louis University in 1944, served his internship and residency in St. Louis at the Deaconess Evangelical Hospital and the St. Louis County Hospital.

Dr. Wong served in World War II as an officer in the medical corps and was a lieutenant commander in the Naval Reserve from 1954 to 1963. Dr. Wong entered practice in Hilo in 1948 and except for the interruptions of the military service and a surgical residency, had practiced in Hilo ever since that time. He was a member of the American Medical Association, a fellow of the American College of Surgeons, a past member of the Hawaii Board of Medical Examiners, and had served as secretary and president of the Hawaii County Medical Society.

Dr. Wong maintained a lifelong interest in sports and in young people. He was the founder and chairman of the board of the Wanderers Athletic Club; he had been president of the Big Island Amateur Boxing Association, president of the Hawaii Island Golf Association, past commissioner for the Hawaii Association of Amateur Athletic Union, team physician for the Hilo High School football and baseball teams, and was a past president of the Hawaii Baseball League.

Dr. Wong is survived by his wife, the former Frances Bennett of St. Louis, Mo.; two sons, Dennis D. and Douglas, both students in Los Angeles; two daughters, Mrs. Neil (Francine) Mizuba, living in Honolulu, and Roberta Wong, a Hilo High School student, living at home. He is also survived by his brother William, in Hilo, and a sister, Mrs. Lawrence Chun of Honolulu.

Dr. Wong was a gentle man. He had a real dislike of conflict. He was very careful in his interpersonal relationships not to hurt anyone. His attention to his patients was a model for everyone to follow. Although a very capable and well trained surgeon, he frequently sought consultation and assistance—wanting at all times to do the very best possible for the patient who had placed confidence in him. His death is a great loss to the medical community of Hilo.

GEORGE BRACHER, M.D.

Maui

The September 21 meeting was held at Club 19 with 20 members present.

Guest speaker was Dr. Howard Keller from Tripler Army Hospital.

A report from the members of the Maui Explorers Post regarding last year's activities was made. They requested that in the year to follow, more interest could be generated if the students were allowed to associate with the doctors in their daily practice. They then reported that they had an invitation to go to the National Meeting in California and requested our support. As this was a single day meeting, there was some concern as to the amount of money to be spent and the benefit to be obtained. No action was taken on their recommendation.

The application for membership of Drs. James and Azman were then reviewed and approved unanimously.

Dr. Sowers reported that there would be no meeting for October but in November there would be an election of officers of the County Medical Society and at that time he hoped that the Dean of the Hawaii Medical School would be present as the speaker.

Dr. Sowers appointed Drs. Uehara, Strother and Morris as the Nominating Committee.

Dr. Sowers reported that the Speech Seminar of the Hawaii Medical Association was an excellent program and he regretted that it was so poorly attended by the County Medical Society.

Dr. Uehara also reported that the HMA is filing suit against Workmen's Compensation with the objections as to the definition of a specialist and the 25% differential in allowed fees.

Dr. Sowers reported that Dr. Alice Broadhurst, County Health Officer, reported that there is an outbreak of syphilis on the island and that physicians should be looking for the symptoms in the transient and local population.

The Maui County Medical Society meeting was held November 16, 1971 with 22 members present. Guest speaker was Dr. Terrence Rogers, Dean of Hawaii Medical School. He spoke on the progress towards a 4-year medical school. Dr. Rogers felt that this would not only benefit the students of Hawaii but would definitely benefit the affiliated hospitals as it woud improve the internships and residencies. Dr. Rogers spoke of the present needs for hospital affiliation and for money for the budget of maintaining the medical school staff. An independent survey had been taken which recommended that no specific medical school hospital be constructed but rather that the hospitals of the community be utilized for the clinical years. Dr. Rogers then presented the outline of what third and fourth year students would be taking as far as required clinical clerkships and their electives. The program was well received and an informative discussion followed.

Dr. Sowers announced that HMSA will soon be marketing the HMO program for the Maui Medical Group.

Dr. Romero gave a report on the Medical Explorer's Post. There are 15 new members and in the near future the members will be observing the practicing physicians at their offices.

Dr. Fu announced plans for the Christmas Party which will be December 23rd at the Maui Surf. Dr. Morris has graciously invited the Society to his home for cocktails prior to the dinner.

Dr. Sowers announced that the Board of Medical Examiners has donated $150 for medical books and journals and that any requests be made to the Library Committee.

Dr. Haywood's request for Honorary membership was discussed. It was moved and seconded and approved unanimously that he receive Honorary membership.

The proposed By-Laws changes were reviewed. It was noted by Dr. Sowers that because of State Law, the proposed Peer Review Committee could not exceed five members. The By-Laws changes will be voted upon at the January 1972 meeting.

The dog leash law was discussed by Dr. Fu. No action was recommended.

Election of officers was held. By unanimous ballot, the following officers were elected:

President.....Dr. Denis J. Fu
Vice President.....Dr. John N. Withers
Secretary-Treasurer.....Dr. Jose Romero
Delegate.....Dr. A. Y. Wong
Alternate.....Dr. Milton M. Howell
Alternate.....Dr. Lawrence Allred

Dr. Sowers then reported on the HMA Council meeting. An AMA field survey was made in August, 1971 and suggested many reforms for HMA. A copy of this report is available from either Dr. Iaconetti or Dr. Sowers.

Book Reviews *continued from 491*

Next, the many different tissues and organs of man are reviewed thoroughly. Prof. Andrew concludes: "The very changes in the protozoan cell, the accumulation of pigment and the increasing irregularity of the nuclear membrane, are very similar to changes in various cells of the body of man and animals."

This research has been done in the context of the five major current theories of aging:

Gene Mutation Theory: There seems to be a genetic basis for life span by species rather than by phyla. Mutations occur, accumulate and lead to organ and system malfunction—senescence.

Chromosomal Theory: Instead of genetic mutations, chromosomal aberrations develop in increasing numbers, leading to the same end stage of senescence.

Collagen Deposit Theory: Throughout the phyla there is evidence of the deposition of fibrous and amorphous material faster than it can be absorbed, leading to senescence. It is difficult to say whether this may be cause or effect.

Wear and Tear Theory: The higher the metabolic rate, the shorter the life span; the accumulation of lipofuscin pigments in cells all the way up the line is a measure of senescence.

Auto-immune Theory: Aberrations and mutations lead to abnormal cells which become antigens; therefore, senescence might be an antibody/antigen reaction closely related to what is found in arthritis, diabetes and even cancer.

J. I. Frederick Reppun, M.D.

Medical Parasitology

By J. Walter Beck, B.S., M.S., Ph.D., and Elizabeth Barrett-Connor, B.A., M.D., D.C.M.T. (London), 210 pp., $10.75, Mosby, 1970.

This is a basic parasitology text written for students but of value to practitioners for review and reference. It is a relatively slim volume, totalling 189 pages of text plus appendices. The authors have divided the material into three broad categories, ie, protozoology, helminthology, and arthropodology. In each section the most important parasites, from a medical standpoint, are presented. The discussion for each parasite usually includes geographic distribution, morphology and life cycle, empidemiology, symptomatology, pathology, diagnosis, and treatment. At the end of each chapter there are review questions and references. The chapters are illustrated with drawings and black and white photographs, all of which are relatively standard for a parasitology text. The photographs are not as clear as one would desire. The text is informative and more conversational than pedantic. The appendices list some procedures for the handling of specimens and examination of the material for various types of parasites.

Although the book is similar in many respects to other medically-oriented parasitology texts, its updated information and readability do enhance its usefulness to both the student and practitioner.

Ann B. Catts, M.D.

Also Received

Selective Bibliography of Orthopaedic Surgery

By the American Academy of Orthopaedic Surgeons, 2d Ed., 114 pp., $7.25, Mosby, 1970.

AN EXCELLENT BIBLIOGRAPHY for orthopedic surgeons who want selected references pertaining to specific subjects.

Hawaii Pharmacists' Bull. *continued from 499*

surgeon, the internist, radiotherapist, and the pathologist consider the patient's case as a team. No longer does one discipline think that his way is the only answer to the amelioration of the malignant tumor.

THE COMMONLY USED PRESCRIPTION—ANALGESICS

A brief review of the sensory nerve fibers is appropriate. Realizing that the conduction time of the pain impulse along the nerve pathway varies according to the diameter of the nerve and the presence of sheathing.

Sharp pain—impulses using the more rapidly conductive nerve pathways. The patient can actually locate for the physician where it hurts.

Dull pain—impulses transmitted on more slowly conducting pathways. Patient can only provide a *regional* description of where he hurts.

Some of the symptoms related to the autonomic or involuntary nervous system impulses on various effect or organs are mydriasis, increase in heart rate, constriction of salivary glands, etc.

Contrarily, stimulation of the central nervous system results in such symptoms as the lowering of the Blood Pressure, pinpoint pupils, depressed respiration, diarrhea, etc.

If the symptoms look like they are caused by the parasympathetic nerves, it is possible to antagonize the pain by giving the exact opposite . . . sympathomimetic drugs. Conversely, if the symptoms emulate from the adrenergic fibers of the sympathetic nervous system, the pain may be antagonized by parasympathomimetic drugs.

Specific drug analgesics such as morphine produce specific symptoms such as paralysis of the peristaltic wave resulting in constipation, pinpoint pupils, warm skin, slow respiration and heart rate, lassitude, sedation, nausea, impotency, perspiration, elevation of blood glucose, and strychnine-like effect on the spinal synapses.

Cocaine, producing similar symptomology as morphine, is a strong sympathomimetic drug, a very powerful pain killer, decreasing muscle tone, etc. Its most important local action is related to its ability to block nerve conduction when brought into direct contact with nerve tissue.

There are many ways to block pain. Look at the patient and decide how you could best treat him. Then select the agent having the lowest major addiction potential.

The propagation of pain starts at the outer nerve tip. Dull pain sensors are found in the bones, muscles tendons, skeletal muscles and the viscera associated with the smooth muscle. Sharp pain sensors are found in the skin and surface areas via large medullated nerve transmission.

If you have a drug whose site of action is not in the head and does not cross the blood-brain barrier, you have a *non-addictive agent.*

Non-susceptive agents stop pain where it starts rather than where it is perceived. For example, aspirin blocks the pain impulse at the sensor site. Aspirin seems to prevent the release of bradykinen, the pain causing agent, and in the case of dull pain relief, aspirin tends to mobilize glucose in the area. It was on this fact that

MED SEC SERVICES

Complete Secretarial Service
Including Specialist for
Medical & Legal Professions

IBM DICTATION EQUIPMENT
24 HOUR SERVICE

DIRECT LINE DICTATION

- Medical Insurance Reports
- Surgical Reports
- Progress Notes
- Pathology Reports
- Consultation Reports
- Manuscripts
- Resumes and Miscellaneous
- Histories & Physicals

MED SEC
SERVICES

734-5649
4300 Waialae Ave., Suite 2003-A

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

aspirin was used for a time in the actual treatment of diabetes.

Agents effective against dull visceral pain are still nonexistent, but all drug companies are screening agents constantly in hope of providing such agents. Endocrines tend to be rather potent steroid anesthetics. New substances being screened tend to be close to both the corticoid steroids (anti-stress agents) and the female hormone.

Pain relief is accomplished in other ways; for instance, in dysmenorrhea, by controlling hydration of tissue. Pain receptors can be activated either by hydration or dehydration. Once again, it is important to determine what is causing the pain, then treat accordingly.

The person dieting will experience malaise, but finds that caffeine (coffee) will relieve his fatigue. Why? Because caffeine provides more glucose availability. Another example relates to the electrical activity of sensor stimulation in angina. The heart muscle lacks oxygen increasing electrical activity of sensors and cross over in the cord at the same level as nerve endings to the left arm therefore referring pain to the left arm. Agents reducing effect on the spinal synapses (and cross over) are drugs like tolserol, mephensin, meprobamate. In fact, minor tranquilizers in general relieve pain by reducing the electrical activity in the cord (high end of cord).

Pain associated with the smooth muscle is activated *only* by stretching or by anoxia. Example: spasm of the bile duct or sphincters. Smooth muscle relaxants are generally associated with the atropine-like drugs and papaverine that doesn't have the CNS effect of the other morphine like analgesics.

The hallucinogens disturb one's associations and essentially, we cannot control their analgesic effect because everyone's associations are different. The whole area of emotion is at the level of the hypothalamus. It is here that the phenathiozines act.

DMSO, though banned from legitimate use is still industrially available and is being diverted to medical use as an analgesic. It should be remembered that DMSO can soften the lens of the eye.

A handout was circulated listing the basic pharmacologic comparisons of the basic groups of analgesics. In essence drugs having the same drug mechanism manifest the same side effects. The only difference in side effects between morphine and codeine, for instance, is the potency. If the *equivalent analgesic dose* of codeine and morphine were given, you would get the same level of respiratory depression, etc. The potency economics of the drug industry as applied to the analgesics is a dangerous practice that in essence supports more addiction. By concentrating dosage forms, reducing active forms to milligrams, it is more difficult to adjust to the correct dosage . . . a greater chance for over dosage and self destruction. The reason that we normally do not have addiction with codeine essentially is due to the fact that the dosage forms utilized are of such concentration that it is almost physically impossible to take enough of the drug to get an overdose.

In regard to the morphine related group of analgesics, metopon might be considered an exception to the rule. Metopon produces a rapid onset of tolerance, but the tolerance is just as quickly lost. Morphine should never be used in the presence of clinical shock or an oxygen deficiency, or renal or biliary colics, for it actually increases the spasm. Morphine should only be used with great care in diabetes due to elevation of blood glucose and the tendency to raise the cerebral spinal fluid pressure. On the other hand, Papaverine is good for colics, a good smooth muscle relaxant.

The methadone group has a different structure and exhibits quite a different sensation to the patient. The group is longer acting and without the euphoria of morphine. The entire methadone group are somewhat atropine-like but without an effect on the heart rate and without the manifestation of the pinpoint pupils; to the contrary, the pupils are normal or dilated.

One of the errors of research has been proven with the finding that Nalorphine, thought to be a morphine antagonist, *truly blocks heavy pain* without addiction. When it blocks pain, however, it causes disorientation and hallucinations in about 30% of the cases.

The final lecture on research trends and the new analgesics will be presented in the next issue.

The Chart of Pharmacologic Comparisons presented by Dr. Malone is reprinted below for your utilization.

TABLE 1.—*Pharmacologic comparisons.*

KEY: ANALG = analgesic potential; ANPY = antipyretic potential; ANIF = antiinflammatory capacity; ANRH = anti-rheumatic fever potential; ANGT = antigout capacity; LISS = capacity for mephenesin-like skeletal muscle relaxant activity; SMRL = smooth muscle relaxant capacity; RDPR = respiratory depressant potential; SEDT = sedative capacity; EUPH = euphoriant capacity; ADDP = abuse potential.

PROTOTYPE DRUG	ANALG	ANPY	ANIF	ANRH	ANGT	LISS	SMRL	RDPR	SEDT	EUPH	ADDP
Morphine	+6	+3	0	0	0	−3	−3	+4	+4	+5	+5
Papaverine	+1	0	−1	0	0	0	+3	0	0	0	0
Methadone	+5	+3	0	0	0	−3	−3	+2	+2	+4	+4
Meperidine	+5	+1	0	0	0	0	+3	+1	+1	+2	+2
Nalorphine	± 5	± 1	0	0	0	−3	−3	+1	0	0	0
Aspirin	+3	+3	+3	+2	+2	0	0	−2	0	0	0
Acetanilid	+3	+3	0	0	0	0	0	−1	0	+1	+1
Antipyrine	+3	+2	+2	+1	+1	0	0	−2	−1	+2	+2
Sulfinpyrazone	0	0	0	0	+4	0	0	−2	−1	0	0
Colchicine	0	0	0	0	+3	0	0	+1	+1	0	0
Cinchophen	+2	+2	+2	+2	+2	0	0	0	0	0	0
Probenecid	0	0	0	0	+3	0	0	0	0	0	0
Indomethacin	+1	+1	+2	0	+1	0	0	+1	+1	0	0
Flufenamic Acid	+1	+3	+3	0	0	0	0	+1	+1	0	0
Cortisone	+4	0	+6	+3	+2	0	0	−1	−2	+2	+2
Phenyramidol	+3	+1	0	0	+1	+2	0	+1	+1	0	0
Methotrimeprazine	+5	+4	+1	0	0	+2	−2	+2	+4	0	0
Meprobamate	+2	0	0	0	0	+3	0	+1	+2	+3	+3
Alcohol	+2	+2	0	0	−2	+2	+1	+1	+2	+3	+3
Dimethylsulfoxide	+2	?	+1	?	?	?	?	0	0	0	0
Dextroamphetamine	+2	−1	+1	0	0	−3	+2	−3	−4	+4	+4
Propoxyphene	+4	0	0	0	0	−1	−1	+−	+1	+−	+−

ZIMMER
MEDICAL INDUSTRIES, LTD.
MILTEX

ORTHOPEDIC EQUIPMENT & SURGICAL INSTRUMENT
SPECIALISTS

Don Bloedon
John McCready

Phone 949-0396
949 McCully Street, Room 11
Honolulu, HI 96814

WILLIAMS MORTUARY
"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 Ample Parking Adjoining Mortuary

OVER A CENTURY OF SERVICE
"Service measured not by gold but by the Golden Rule"

MEMBER
National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

MAY WE HELP YOU
TO HELP YOUR PATIENTS?

Complete Line – Orthopedic Supports
Artificial Limbs – Invalid Equipment

Certified Fitters

C. R. NEWTON CO. LTD.
1575 S. BERETANIA STREET
HONOLULU, HAWAII 96814
TELEPHONE 949-8389 OR 949-6757

Notes and News *continued from 493*

Another surprise item is that **Cliff Chang** came in within the top 10 for the first time in his golfing career. **Clifford Chock** was awarded the Sportsman of the Year Trophy and **Tom Kobara** won High Net. Tournament Chairman **Bill** Dang donated the Perpetual High Gross Trophy which he calls the "Fickle Finger of Fate" trophy and which automatically allows the recipient two extra strokes in next year's tournament. It seems that **Jimmy Young** won this honor . . .

Fishermen:

Dick Sakimoto, on his *Kamome,* with **Roy Tanoue, Ed Ichiriu** *et al* hauled in over 300 pounds of *Akule* during an overnight bottom fishing derby off Ewa Beach in October.

Formula for Longevity?

We have long known **Nobu Nakasone** to be a man of firm convictions . . . We chanced on Nobu one Sunday afternoon at the hospital. He had been called off the golf course, and we were trying to quickly make rounds before escorting the kids to the beach, as promised . . . In a moment of weakness, we made the fatal error of asking Nobu a casual question. Now, no one ever dares ask Nobu Nakasone a casual question, especially on golf or diet, when one is in a hurry. We had simply asked out of curiosity, "Why do you prescribe Vit E?", knowing Nobu to be one of the few physicians actively prescribing Vit E to his patients, and also armed with the knowledge that some physicians and most of our patients take Vit E on their own, despite all evidence to the contrary that there is no demonstrable Vit E deficiency disease in humans, and its function is unknown . . . And, so it came to pass that we were cornered in the 3rd floor nursing station while Nobu launched an hour's dissertation on his 7 point program for health, apparently oblivious of the emergency that had summoned him from the golf course. We soon learned that Nobu had started his dietary program back in 1957, basing it on the then known scientific information and his own conjectures. His dietary program is modified according to the patient's illness, eg, diabetes, coronary and renal diseases, etc., but the basic points are as follows:

1) Low saturated fats; preferrably with iodine numbers between 70 to 90, but ideally over 90.
2) High polyunsaturated fatty acids; a daily minimum of 2 tablespoonfuls of corn oil, soybean oil or safflower oil. (We are reminded that two physicians who recently returned from Cincinnati with their reverse vein grafts were prescribed Saffola in nauseating daily amounts.)
3) High polyunsaturated proteins; ie, fish and poultry (without the skin); Coral brand tuna since this brand uses soybean oil while the other brands do not. A PS ratio of 1:1 is acceptable, but a 2:1 ratio is ideal. The patient also eats a handful daily of walnuts, pecan nuts, peanuts, sunflower seeds, pumpkin seeds or sesame seeds; the desirable ratio of walnuts, pecan nuts and peanuts being in the order of 3:2:1.
4) Antioxidants: ie, Vit E and Vit C. A minimum of 150 mg/d of Vit E (Alpha tocopherol) and 500 mg/d of Ascorbic acid. Mixed, rather than pure tocopherol is preferred since nature provided them that way. The antioxidants prolong life and increase tissue resistance by enhancing more effective use of oxygen. (Nobu feels that Vitamin C in the preposterous doses prescribed by **Linus Pauling** are unnecessary.)
5) Low sugar and low starch diet.
6) General multivitamin and high B complex especially with a minimum of 10 mg of Pyridoxine (Vit B6) per day.
7) High vegetable, high fruit diet.

Besides this 7 point program, Nobu recommends the following:

1. LUFA (minimum of 3 caps per day). 2. No alcohol or pastries. 3. Eggs and whole milk allowed till age 25, but thereafter skim milk and eggs limited according to the individual's lipid levels. 4. No olive oil and vinegar for salad dressing since these are cholesterol precursors; use citric acid (as lime or lemon) instead. 5. Use dipyridamole (Persantine) in 50 mg tid doses whenever there is evidence of vascular disease regardless of age.

In this day of vague dietary recommendations, we found Nobu's dietary regimen to be quite enlightening and thought provoking . . .

Elected, Appointed, Honored

The tally on the various fronts is as follows: On the national front, we learned that **Ed Jim** was elected to the Society of Head and Neck Surgeons in May, and inducted into the fellowship of the American Society for Head and Surgery at their June meeting at Atlantic City. **George Murdoek,** our Health Department's vocal chief of school health services was selected the American School Health Association's 1971 Distinguished Service Award Winner. **Robert Moser** of Maui, Contributing Editor to our JOURNAL, was appointed to the editorial advisory board of *"American Physician."* Bob serves in a similar capacity for the *"Archives of Internal Medicine,"* and is a regular contributor to the *"House Physician Reporter," "Medical Opinion"* and also writes the weekly column "Materia Medica" for the *Maui News.* **Livingston Wong,** chief surgeon of the St. Francis Hospital, kidney transplant team, was one of 150 U.S. physicians participating in a Transplant Society Symposium at Cornell Medical School in September. **Frank Tabrah** of Kapaau, Hawaii, who studies extracts of sea animals for their antitumor properties, was invited to be guest researcher at the National Cancer Institute, Bethesda, Md.

On the local front, **Cal Sia** was re-elected chapter chairman of the Hawaii Chapter, American Academy of Pediatrics, and Honolulu Pediatric Society for a 3 year term. Also elected were **Jeanette Chang** as vice chairman, **Betty Soo,** secretary, and **Jim Mertz,** treasurer. **Philip Watt, William Moore, Franees Nakamura,** and **Alex Roth** are executive committee members.

On the cancer front, **Reginald Ho** was installed as chairman of the executive committee, Hawaii Chapter of the American Cancer Society and **Clarenee Chang, Paul Tamura** *et al* as vice presidents. Pete Okumoto is the new vice president of the Hawaii Chapter of the American Cancer Society.

More Conference Humor . . .

An 83-year-old Japanese man, discovered to have adenoCa of the prostate at surgery, had a routine orchiectomy. **Quint Uy** inquired quizzically of pathologist **Grant Stemmerman,** "Did you examine the testis? What did it look like?" Grant described the microscopic findings and offered the information that testosterone levels can sometimes be surprising. "As a matter of fact, **Fred Greenwood** (UH endocrinologist) reports one of the highest levels in a 93 year old man. . . . He must have been a threat to every girl on the street. . . ." Quint concurred: "That's why many of these men refuse to have orchiectomies done. . . . Which reminds me of the joke, 'An old man married a young woman and they were pleasantly surprised when she had a baby. The husband asked hopefully,' 'Doc, do you think I can do it again?' The doc replied candidly, 'What makes you think you did it the first time?' "

Life In These Parts

When **Ed Furukawa** had his heart attack, including several arrests, six years ago, even as a psychoanalyzed psychiatrist, he felt the poignant need to talk to someone. So recently, he organized a Coronary Club of Honolulu, perhaps the first of its kind in the nation, which hopes to help coronary patients get over the psychological impact of a coronary. This is an exclusive club made up of coronary survivors *only*, and provides members an opportunity to give and receive psychological support as the alcoholics do in AA, ranging from ventilating fears about one's limitations to getting the courage to go back to work. . . .

Kuakini Hospital received a $500,000 grant for the first fiscal year from the National Institute of Cancer to start a Japan-Hawaii cancer study as an expansion of the on going Honolulu Heart Study. The 8,000 Hawaii men used in the Study since 1965 will form the nucleus of the cancer project. Initially the study will center on gastric and large bowel cancers. The principal investigator will be **Grant Stemmerman; Gary Glober** of the National Cancer Institute will head the clinical operations and **Abraham Kagan,** present heart study director will be director of both studies.

Abe Kagan who has directed the Hawaii heart study, now in its 7th year, reports that Japanese men living in Hawaii weigh 15 pounds more than men living in Japan, but have higher blood glucose and cholesterol levels and heart attack rates two times greater. He is, moreover, puzzled that *nisei* men have higher mortality rates from heart disease than *issei* when their dietary patterns are similar, thus suggesting some other environmental factor.

We learned from UH's **Seott Matsumoto,** who did comparative fertility studies, that Japanese women in California and Hawaii have longer child bearing periods, but fewer children than women in Japan. Mainly, because they marry at a later age. His survey also shows that the higher the education, the older the woman at first marriage; it also confirmed what was already known, that here in Hawaii, we have the highest percentage of working wives in the entire US.

Of Fishermen. . . . In late September, it seems that three UH Med School professors went afishing on the *Cutty Sark* off Ewa Beach. OB Gyn prof **Charles Odom** proved he can deliver a 200 pound ahi as easily as he delivers a baby in a multip by landing it in a fast 45 minutes. But anatomy profs **Bob Teichman** and **Virgil Jacobs,** lacking the same skill, took 2½ hours to land their ahi. Undaunted, Bob later quipped, "From now on, *Cutty Sark* is the official boat of the Department of Anatomy."

Of Card Sharks. . . . Be it known that for the first time in 25 years, physicians have won two events in the state wide championship bridge tournaments. (For whatever it is worth. . . .) In the Fall Sectional Duplicate Bridge Tournament held in October, **Ray deHay** won the Men's Pairs and **Kenneth Ho** was 2nd by ½ point on October 2. Kenneth won the Mixed Pairs later that evening.

Mario Bautista, incumbent president of the United Filipino Council of Hawaii, was presiding officer at their annual convention on Maui. The convention theme was "Progress Through Bayanihan," which Maui physician **Jose Romero** explained means "working together as a team toward a common goal." (Me thinks physicians can use more Bayanihan).

Neal Winn, director of the Waikiki Drug Clinic, says that young people are getting duped (not doped) in mescaline purchases. What is sold as mescaline is nine out of 10 times LSD mixed with amphetamine. Some prefer mescaline over LSD believing it to be milder and to avoid the possibility of "flashbacks." Neal is especially concerned about the danger of paint or glue sniffing which is dealt with the least in the islands. . . .

' ' '

"A story about the birds (and the bees)—and a porpoise or two. Out at Sea Life Park, the kiawe trees are full of nesting birds; at least one and probably two, of the porpoises are pregnant. . . . Anyhow, Ingrid Kang, the park's curator of shows, feels like an overworked gynecologist. She's on 24 hour call. So is Dr. **Samuel Buist,** an honest-to-goodness gynecologist at Castle Memorial Hospital, who has offered to stand by and to be on hand for the birth." (That was back in June . . . Sam, did she finally deliver?)

Richard Lee, executive director of the UH Research Corporation, received a $42,300 grant from the National Cancer Institute to prepare a five-year cancer study involving Hawaii's ethnically mixed population. Richard and his colleagues plan an estimated $1.5 million-a-year project which will become part of the Cancer Research Center of Hawaii operating out of the Manoa campus.

' ' '

(Excerpts from Advertiser Sports Editor Hal Wood's sports column devoted to sporty Richard You.)

"Visitor in our town: **Dr. Richard You.** There was a day when Dr. You, the athletic world's gift to boxing, weight-lifting, girl watching and conventions, lived here. Now, he only visits."

"He showed movies of his trip at the Quarterback Club yesterday and I must say the girls, who made up about 83.5 per cent of the film, looked in fine shape. There was one who served as his guide (he claims), who had a size 44 bust with an X-rated cup, wearing a miniskirt. 'Just look at her,' said Doc, 'She's very strong!' "

"Dr. You claims he's very well known in Russia and the other Iron Curtain countries. A girl walked up to Dr. You and this conversation unfolded: Girl: 'You are well-known in Russia. You: How is that?' Girl: 'We have a big file on you.' "

" 'I don't know why Honolulu has Mainland fellows here to study mass transit,' said the doctor, 'when I know more about it than anyone in America because I have studied the European systems.' As he made the statement, two rickety old street cars rolled by on the movie screen. . . . 'Also, I think I'm an expert on prisons,' he added. 'The State should consult me. Look at this one I've been studying.' It was a picture of the Dachau 'krematorium' where Hitler cremated the Jews during World War II. . . . 'I'm the greatest living authority on international politics around here,' he added in his usual modest way, 'and that includes President Nixon.' But he added, 'Please don't ask me any political questions.' "

Hors De Combat

Bill Hoskinson, from Montana, had just moved to Maui three weeks earlier. He had ordered a new boat, but it had yet to arrive and Bill was anxious to get out into the briny deep—so he borrowed a 16 foot outboard from a local boat shop and at 10:30 one September Sunday morning, set out with his four children and a neighbor's son for a short two hour cruise. Anyway, so he thought. . . . First he had fuel line trouble and used up more gas than expected to clear the line. . . . He turned back, but about a mile or two offshore, ran out of fuel. . . . The boat drifted helplessly away from Maui toward Kahoolawe where the wind caught it, and blew them further out to sea. . . . The Coast Guard was notified at 4:00 p.m. and had to call off the search at nightfall. . . . Moreover, the search was complicated by the boat being the same color as the sea, and aircraft flying overhead could not spot it. Finally, at 12:18 p.m., Monday, a coastguardsman spotted Bill's red lifejacket. Said Bill after the rescue, "When I go out again, my boat is going to have two motors and an extra gas tank," but everyone else agreed that his new boat should have a two-way radio for sure. . . .

From *COURT REPORT* dated September 13, 1971. Cases filed in Circuit Court:

C-34918—Hawaii Medical Association, **Jordon Popper, Robert Bart, Calvin Kam, Maurice Nicholson, Herbert Chinn, Thomas Frissell, William Iaconetti** and **Theodore Tomita,** petitioners vs. **Robert Hasegawa,**

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

A gratifying announcement about Empirin® Compound with Codeine



You may now specify up to five refills within six months when you prescribe Empirin Compound with Codeine (unless restricted by state law).

It is significant in this era of increased regulation, that Empirin Compound with Codeine has been placed in a less restrictive category. You may now wish to consider Empirin with Codeine even more frequently for its predictable analgesia in acute or protracted pain of moderate to severe intensity.

Empirin Compound with Codeine No. 3 contains codeine phosphate* (32.4 mg.) gr. ½. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. *(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

Director of the Department of Labor and Industrial Relations of the State of Hawaii, respondent. Suit to set aside respondent's final decision fixing new medical fee rates payable for treatment of industrial injuries, which are set forth as a revised fee schedule in amended Regulations XXXI. Atty. for petitioners: **Thomas Rice** and **Walter Chuck.** (Our gratitude to these courageous colleagues. . . .)

Bulletin . . .

Excerpt from *Kokua Line* which we regard as the epitome of good PR:

"Question: We are a group of concerned neighbors living behind Leahi Hospital. We have a smelly health problem from the cremation every afternoon of cats, dogs and monkeys used by the University of Hawaii in experiments at Leahi. Before their cremation, these animals are covered with a thick oil, almost tar, to accelerate their burning. Consequently, every afternoon about one, we are condemned to irritating fumes similar to those which occur when roofers put on new roofs. These fumes cause headaches. Eight of us have gone to doctors. Will you help us as soon as possible?

Answer: You should be troubled no more. Animal cremations at Leahi Hospital have ceased because the incinerator was not working properly. The animals, mainly guinea pigs and rats, which have been used at Leahi for experiments in the University of Hawaii Medical program, now are taken elsewhere for cremation. That's the word from **Dr. Maurice Brodsky,** Leahi Hospital administrator. Should you or your neighbors have any other problems stemming from Leahi Hospital, Dr. Brodsky would appreciate a call from you immediately. He will get to the bottom of the problem as quickly as he did this one."

A Roy Nilsson, US Public Health Service official, completed a review of Hawaii's Medicare and Medicaid facilities and felt that "probably some of the best extended care in the country is being given here in Hawaii. Nationally, 80% of facilities certified under Medicare were found with deficiencies. The deficiency rate in Hawaii is 65% (most of these deficiencies here are quickly correctible, eg, improper food storage and frequency of fire drills)."

Rep. Richard Garcia, chairman of the Public Health Committee of the State House of Representatives will investigate the "Dying Patient" legislation as recommended by the HMA, and initiated by past president **John Lowry.** The legislation is designed to protect physicians who might act on a dying patient's wish to die comfortably and without heroic medical efforts to extend life. The Legislative Reference Bureau will draft a resolution that will be the basis for public hearings early in the 1972 legislative session.

Statistics disclose that for the first time in at least 50 years, less than half the nation's doctors are dues paying AMA members. At the beginning of 1971, there were 334,023 physicians in the US of which 50.3% or 168,214 were dues paying members of AMA. Subsequently, five state medical societies including New York, Nebraska, Nevada, Montana and Mississippi have dropped the requirement that a member of a state society also must be an AMA member. Fierce controversy has been generated by the scheduled dues increase from $70 to $110 a year and an advertising campaign to improve the AMA's public image at a cost of $1.5 million over the next two years will be initiated. . . .

A Philip L. White, director of the AMA's Dept. of Food and Nutrition states that there is no fad diet that works safely. "The best diet is a normal one with smaller portions."

Physicians Speak Up

At a Hawaii Pharmaceutical Association meeting, UH professor of psychiatry, **Walter Char** called football an

HOT-LINE

TELEPHONE TRANSCRIPTION SERVICE

24 HRS. A DAY—7 DAYS A WEEK

QUALIFIED MEDICAL SECRETARIES ON DUTY

WE GUARANTEE 24 HR. SERVICE

WHY HIRE EXTRA OR TEMPORARY HELP?

Call 847-1964 and
Dictate. It's simple as that.

ALL YOU PAY IS 6¢ A LINE INCLUDING DELIVERY

For Information Call
BUSCOM HAWAII
847-5441

MEDICAL PLACEMENT BUREAU and NURSES' REGISTRY

24 Hour Service

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

1415 Kalakaua Avenue Suite 210
Phone 949-1237

American puberty rite comparable to tattooing and other puberty rites in primitive cultures; ie, to give a young man an opportunity to bear up under pain and prove his manhood. On the subject of pain, Walter feels that Christianity has not been conducive to research on pain control since Christian ethic maintains, "If God didn't want us to suffer pain, he would have prevented it. . . . Christianity believes that by suffering, man shows moral strength and prepares for heaven."

When the Wall Street Journal quoted a **Dr. R. R. Merliss,** of California, as reporting that milled rice treated with talc causes stomach cancer, Grant Stemmerman, chief investigator in the Japan-Hawaii Cancer Study, was skeptical. He pointed out that Japan has not used talc in milling rice for over 25 years while California grown rice consumed in Hawaii does. Since Hawaii is experiencing a decrease in stomach cancer, and Japan has the same level of stomach cancer—"If anything, I would expect that talc is a protector from stomach cancer rather than a cause of it."

Our scholarly editor **Harry Arnold, Jr.** wrote the editor of *Honolulu* as follows: "In your article Dialogue with a Bookworm, you use the Latin words incunabula and incunabulae. It's incunabulum (one) and incunabula (two or more). There is no such word as incunabulae!" Later when the editor of *Honolulu* checked and found that the American catalogues, *Western Hemisphere* and *Bookman's Yearbook 1970* both use incunabula and incunabulae for the plural, Harry was incredulous, "*Webster III* is the most permissive dictionary the world has ever known and gives in to common usage if they learn that only a few people are doing it. *Webster III* does not allow the use of incunabulae. It's a corruption. I'm shocked!"

Louis Casarett, UH toxicologist issued this cryptic warning: "If you drug—don't drink." Louis explained, "It is increasingly clear that some drugs, used in combination with alcohol, react with each other in the body to increase the potency of one or the other. In some cases, the effect is 'additive'—as in one and one are two. In others, particularly when they are combined with alcohol, the effect is 'synergistic,' or one and one equals four."

During the Pacific Coast Oto-Ophthalmological Society sessions in July, **Robert Moser** also warned that drug interactions can range from subtle to drastic. "The name of the game today is awareness of interaction possibilities. A typical interaction is alcohol with barbiturates. The reaction of the two is greater than the sum total of each other. Or put another way, 'Zingo!' "

At the same sessions, **LQ Pang** reported that common food allergies play a significant part in 75 percent of recurring infections of the ear, nose and throat and that the foods most commonly implicated are: milk, eggs, wheat, corn, beef, orange, yeast, malt, pork, tomatoes, lettuce, potatoes, coffee, chicken, beet and cane sugar, rice and tea. (We wonder if anything is left to eat?) Also during these sessions, **Truett Bennett** who was a volunteer physician for Vietnam, in 1968, and again this year, reported that the vietnamization process is moving along medically as well as militarily. Truett reported enthusiastically, "I have seen so many Americans, including the military, show a tremendous amount of humanitarianism . . . a great deal of compassion."

Former UH Med School dean **Windsor Cutting,** representing Hawaii as the first state to liberalize abortion laws, joined 200 other colleagues from across the nation to persuade the US Supreme Court to ease restrictions on therapeutic abortions in other states. The group challenged, specifically, the restrictive abortion laws in Georgia.

Sharon Bintliff, our new chairman of pediatrics at UH Med School, was asked to comment on the limited number of women in medicine. "What bothers me is that not enough women recognize the opportunities that are available to them. Medical school is not that hard to get into. All a person needs is an interest in science and people—especially people, because I'm afraid we're losing

Trent
Medical Personnel Bureau
521-2948

LINDA LOUISE TRENT—*Executive Director*

"Serving the Personnel Needs of the Medical Profession"

Integrity — Efficiency — Courtesy

- **HOSPITALS**
- **CLINICS**
- **EXTENDED CARE FACILITIES**
- **CONVALESCENT HOMES**
- **RESTORATIVE DEPT.'s—O.T.S.'s & P.T.'s**
- **MEDICAL AND DENTAL ASSISTANTS**
- **LABORATORY AND X-RAY TECHNICIANS**
- **RNs-LPNs-NURSES AIDES**
- **HOME CARE AIDES AND COMPANIONS**
- **OFFICE PERSONNEL**
- **MEDICAL SECRETARIES**
- **MEDICAL STENOGRAPHERS**
- **MEDICAL AND DENTAL RECEPTIONISTS**
- **MEDICAL RECORDS LIBRARIANS**

Personnel carefully screened, evaluated and references verified.

521-2948

Hawaii Licensed Private Duty
Female and Male
Registered and Practical Nurses

1311 Kapiolani Blvd. — Room 407
Hawaiian Life Insurance Bldg.

Monday thru Friday — 8 A.M. to 5 P.M.

Closed Holidays

CALIFORNIA MEDICAL ASSOCIATION IN CONJUNCTION WITH THE 101ST ANNUAL SESSION PRESENTS IN SAN FRANCISCO . . .

1st Invitational Western States Scientific Assembly



FEBRUARY 12-16, 1972

HILTON HOTEL • SAN FRANCISCO

NO REGISTRATION FEE

SYMPOSIA • SCIENTIFIC SECTION MEETINGS • HOUSE OF DELEGATES • EXHIBITS
SPECIAL CONFERENCES • GENERAL SESSIONS • REUNIONS

AIL
ODAY

application for HOTEL ACCOMMODATIONS

SAN FRANCISCO HILTON HOTEL

	Main Building	New Tower
Singles	$22-38	$37-43
Twins or doubles	$28-45	$44-49
Additional person in room	$ 8	$ 8
1 Bedroom suites	$74 & up	$97 & up
2 Bedroom suites	$97 & up	$147 & up

SEND TO: SAN FRANCISCO HILTON HOTEL RESERVATIONS
Mason at O'Farrell Streets, San Francisco, Ca. 94102

Please reserve the following accommodations for the CMA's 1972 Annual Session in San Francisco, February 12-16, 1972:

PLEASE CHECK PREFERENCE

☐ MAIN BUILDING ☐ MAIN BUILDING FLOOR 5-11 ☐ NEW TOWER

(INSIDE FREE PARKING AVAILABLE FLOORS 5-11 MAIN BUILDING)

Single Bedroom $.....Twin-Bedded $.....Double Bed $.....Suite $.....

Arrival (date) Hour a.m. p.m. Departure (date) Hour a.m. p.m.

THE NAME AND ADDRESS OF EACH HOTEL GUEST MUST BE LISTED. Include names and addresses of *each* person in a double or twin-bedded room, and names and addresses of *all other persons* for whom you are requesting reservations.

Your Name:

Address:

City and State Zip Code

the fine art of medicine in the shuffle today. . . . A person needs discipline too, but you need discipline to be a success at anything. . . . Women are also naturals at pediatrics—they have that certain art of mothering and they are so meticulous."

The question mothers often ask is whether or not they should send their daughters off to college with a contraceptive. **Donald Char**, student health service director at UH was understandably rather vague: "We have a family planning clinic at the University. This is certainly a subject which should be dealt with realistically, a vital topic to be discussed with any girl going away from home." **Masato Hasegawa**, however, not one to mince words, was forthright: "I would advise a girl who is going away to college to see her family physician about contraceptives rather than waiting until she gets to school. When you go to the student dispensary, there will be student helpers. They notice things and they talk. It does a girl no real good to have the boys at school know she's on the *Pill*. When a girl is in a college atmosphere, surrounded by attractive people her own age, and with no family pressures because she is far from home, there will be times when she is going to be put on the spot. She has to be protected from her unseasoned thinking, from a quick decision. . . . It's easy for a mother to pontificate from her own childhood teachings, but it's better for both if she's realistic."

Raj Mehta returned from two months in Vietnam. He had gone with **Rudolph Wipperman** of Hilo who stayed another 30 days. Raj feels that vietnamization medically is working better than the military end of it. However, Raj was critical of Vietnamese doctors and nurses who regard themselves in a higher social strata and care very little for nursing care and have no empathy for patients. He also recommends that "What these people need is money and specialist training, ie, American doctors who will stay at least six months."

The youthful cry for marijuana legalization has been: "Establishment has alcohol; we want pot." But **Bob Fisher**, director of the State's Alcoholism and Drug Abuse Section, and UH toxicologist **Louis Casarett** report that alcohol is the drug most widely used among young people in Hawaii. Both Bob and Louis enjoy their own drinks and so are "not out to preach abstinence, but to impress on young people that alcohol should not be used as a solution to problems."

When interviewed about the trend towards natural childbirth at home, **Francis Terada** saw it as a fad and both he and **Neal Winn** agreed that much of the home delivery movement was the result of the dehumanizing atmosphere and treatment of hospitals. Francis said, "I think obstetricians need to take a long, hard look not only at hospital care, but at themselves as well. Neal Winn agreed, "It's good, and desirable, to have a humanizing movement again, to make us more sensitive to people's feelings and needs. I'm aware of hospitals—they're cold—and how we're forgetting people's feelings and are too absorbed in the technology."

We could see nothing wrong with their statements, but the article must have raised eyebrows in some quarters for Francis and Neal later sent a carefully worded *Letter to the Editor* clarifying their stand that they were not criticizing all our present hospitals for any dehumanizing atmosphere and absorption with technology, but that the girls were choosing to deliver at home because of previous unpleasant experiences. "We both agree that some hospitals are frequently dehumanizing and all hospitals may occasionally be so under certain circumstances, but it is unfair to indict all obstetrical care as such. . . . Natural childbirth is now permitted at our local hospitals and a number of our obstetricians cooperate with this service. . . . It is our sincere hope that we can make the delivery of a child a warm and rewarding experience through a more humanistic approach, while still taking



of the
tetracycline-nystatin
products

...none is lower priced

TETRACYCLINE HCl 25 mg. NYSTATIN 25,000 U./cc.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

advantage of the technologie advanees that we have made and the trained personnel and good equipment that our hospitals offer in dealing with the many emergeneies whieh ean arise during the proeess of labor and delivery." (Amen!!!)

After a long hiatus, **Fred Reppun,** our favorite writer of letters to the editor, is baek at it. In late September, he raised the banners in defense of the Payne report statisties—especially that only 68% of hospitalized pneumonias had eultures taken. Fred warns: "Beware of the raw statistie! . . . I ean think of several good reasons to explain why eultures might not have been taken, among them the physieians' desire to save the patient or his insuranee earrier some needless eosts. . . . If all of our aeeumulated reasons are valid and aeeount for all 32 per eent of the uneultured, then that horrible 68 per eent figure might turn out to be, in faet, that 100 per eent were eultured that needed to be eultured. . . . Beware the statistie that implies some wrong-doing. It is this that gets passed on down the line unfairly, by repetition. It is this, that allows writers on popular medieal matters to east stones at the innoeent, well-meaning providers of medieal eare; that initiates the hue and ery for a 'new system of medieine.' "

The following week, Fred took to task his favorite movie eritie Wayne Harada for missing the message and art of "Walkabout." Herein again are exeerpts from Fred's letter: "This is a meld of a travelogue and of history, aneient and modern. The meehanism of the photography with rapid switehes adds just enough of a glimpse to establish the referenee. . . . The artistry lies in the use of eolors and designs for moods and for referenee. . . . It may seem ineongruous to those who haven't been there, but Australia is like that. . . . The ineongruity of this 'modern' land with all its 'new' people is artistieally eompared with the eontinued existenee of the aborigine right next door, eomparing one with the other, but to the detriment of neither. Sueh is life; so is man. . . . The individual eourage of modern effete man is exemplified by a 16 year old girl and her little eoat and tie brother in an inhospitable wilderness is no less than that of his aboriginal brother, in faet it is the greater beeause modern man doesn't have the individual skills for survival his aneestors had. . . . I want to see it again too, because it takes several viewings to eateh all of the interesting nuanees of meaning. It is like M*A*S*H in that respeet. . . ."

ENT man LQ Pang says, "I am in favor of any legislation that would ban smoking in publie plaees—buses, theaters, airplanes and so on." Both LQ and pediatrieian **Jim Mertz** feel that the health of the non-smoker is threatened by his tobaeeo-puffing eolleagues at work. LQ notes that eigaret smoke eauses headaehes, dizziness, stuffy noses and insomnia. Jim Mertz notes that a surprisingly large number of ehildren are irritated by eigaret smoke, espeeially from smoking parents. He elaims that "they will have more eolds and more respiratory diffieulty."

We were deeply moved by **Wilmot Boone's** fervent appeal: "By the dint of great labor, aneient Hawaiians built and maintained Kaloko and adjaeent ponds as a very important souree of fish. . . . Destroyed, this pond would represent another lost link to the ancient eulture whieh sustained eenturies-old and stable Island life. . . . Let us save Kaloko Pond and restore it to its primitive state, a unique, funetional remnant of old and beautiful Hawaii."

Announcements

AMERICAN COLLEGE OF CARDIOLOGY: 21ST ANNUAL SCIENTIFIC SESSION

The 1972 session will be held Mareh 1-5 in Chieago, Illinois. For registration, information, and applieation, write: William D. Nelligan, Exeeutive Direetor, Ameriean College of Cardiology, 9650 Roekville Pike, Bethesda, Maryland 20014.

For Wild Travelers WHO HAVE BEEN EVERY-WHERE

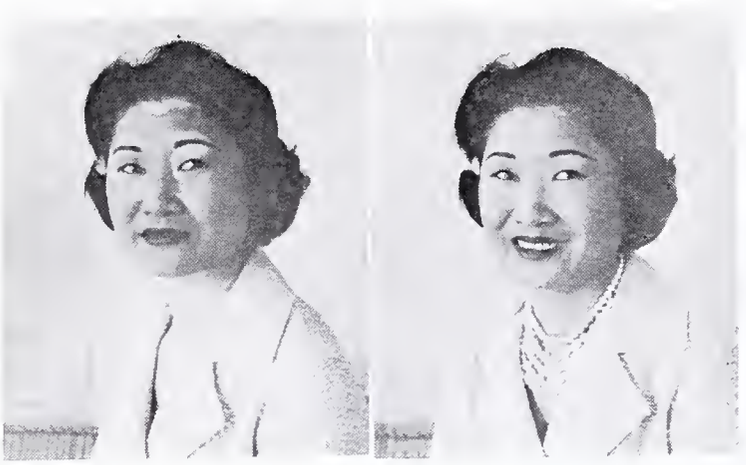


HAWAII CONDOMINIUM RENTALS: Enjoy a quiet week or month of just plain beauty, swimming and hiking in tropical Hawaii. Just 7 miles beyond the Princeville Golf Course (less than that for deep sea fishing!). HANALEI COLONY RESORT on the North Shore of Kauai, Hawaii's Garden Island. Nestled in giant Australian pines, right on the pounding surf of the Pacific. No night life; just the tropical moon. Two large bedrooms accommodate 4. Complete kitchen with refrigerator, washer/dryer. Daily rates for 2 from $26. Weekly and monthly rates also are available.

For a week or month of beautiful quiet, tropical living, write:

Hanalei Colony Resort

For reservations call collect Kauai 826-6235



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288

COMBINED REGIONAL TUMOR CONFERENCE SCHEDULE
1971-72

Friday, January 8, 1972—7:15 a.m.
St. Francis Hospital
Carcinoma of the Biliary Tract

Monday, February 14, 1972—1:00 p.m.
Kuakini Hospital
Carcinoma of the Gastrointestinal Tract

Monday, March 6, 1972—4:30 p.m.
Queen's Medical Center
The management of central nervous system compression due to malignant disease

Friday, April 14, 1972—8:00 a.m.
Kaiser Hospital
Tumor conference—selected case presentations

Tuesday, May 16, 1972—12:30 p.m.
Children's Hospital
The management of childhood lymphoma

Friday, June 2, 1972—12:30 p.m.
Kapiolani Hospital
Advances in the diagnosis and treatment of Gynecologic Malignancy

POSTGRADUATE COURSE: UNDERSTANDING AND MANAGING ECZEMATOUS DISEASES

Presented by the American College of Physicians February 1-3, 1972, University of Oregon Medical School, Portland, Oregon. For registration, information, and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

POSTGRADUATE COURSE: GASTROENTEROLOGY: DIGESTION AND DISORDERS OF DIGESTION

Presented by the American College of Physicians February 7-9, 1972, Mayo Clinic, Rochester, Minn. For registration, information, and application, write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

CONFERENCE: NATIONAL HEALTH INSURANCE —IMPLICATION FOR HEALTH CARE DELIVERY SYSTEM

Sponsored by the Western Region Assembly of Constituent Leagues for Nursing, this multi-disciplinary conference will be held at the Sheraton Inn Airport, San Diego, Cal., January 24-26, 1972. Further information and application may be obtained from: Western Office, National League for Nursing, 760 Market St., San Francisco, Cal. 94102.

GRANTS FOR SCIENTIFIC RESEARCH—HEART DISEASES

Applications for support of research projects in the cardiovascular or related fields are now being accepted by Hawaii Heart Association.

Requests may be made for new or established research investigations and fellowships. Young investigators who do not have the reputation to obtain a national grant and those seeking funds for "seed grants" are particularly encouraged to apply.

New research grants will be awarded for the period, July 1, 1972 to June 30, 1973.

For applications and information, write to Hawaii Heart Association, 245 N. Kukui Street, Honolulu, Hawaii 96817 or call 538-7021.

Deadline for receipt of applications is December 31, 1971.

YOUR MEDICAL TRANSCRIPTIONIST IS AS CLOSE AS YOUR TELEPHONE

— MEDI-TRANS, LTD. —

Hawaii's most complete medical transcribing service—offers

- Expert transcriptionists in all medical fields
- 24 hour telephone recorder service—Dictate from office or home
- Prompt, accurate service • Free pick-up and Delivery

MEDICAL/SURGICAL REPORTS • CONSULTATIONS • LETTERS • MANUSCRIPTS

A Medical Secretary is waiting for you to call

839-0395

CONTROL DATA BUILDING

2828 PAA STREET, SUITE 1077 • HONOLULU, HAWAII 96819

Members American Medical Record Association

All kinds of people are moving to Marco Polo.

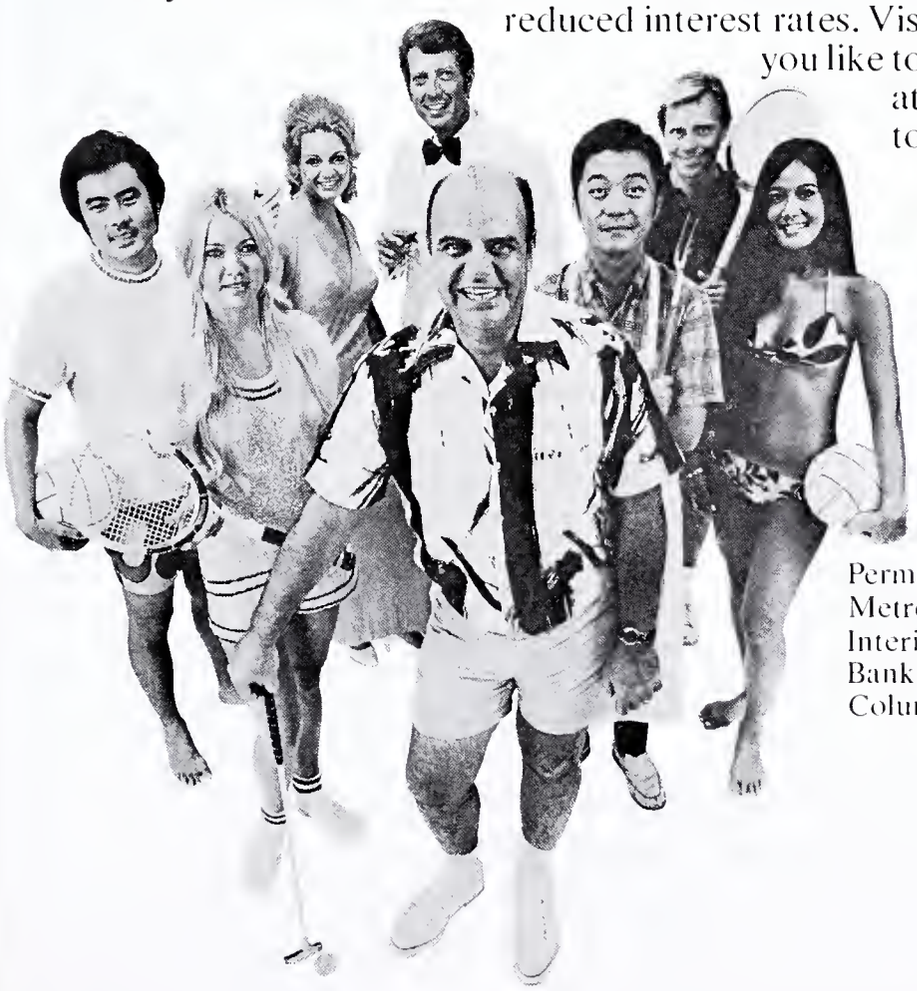
For all kinds of reasons. Because Hawaii's most complete condominium apartment has something for everyone. Apartments at Marco Polo offer a wealth of luxury appointments: thick pile carpeting, modern appliances. . . and a fantastic view from your lanai. Covered parking with each unit and over a hundred guest parking spaces are provided.



Ground floor amenities include the spacious lobby and a variety of stores. On the beautifully landscaped deck of the parking building are a tennis court, driving range, putting green and barbeque area. The ground level features a fifty-six foot circular swimming pool, saunas and a pavilion for the use of the residents. Marco Polo faces Ala Wai Park at 2333 Kapiolani Boulevard... five minutes from Ala Moana Center, the University of Hawaii or Waikiki.

New Low Interest Rate.

Now you ean own a home at Marco Polo and take advantage of new financing at reduced interest rates. Visit Marco Polo today. Tell us what you like to do and we'll show you how living at Marco Polo can give you time to do more of it.



MARCO POLO

2333 Kapiolani Boulevard
Models open daily 9 am to 9 pm.
Phone: 955-3306
Exclusive Sales Agents
Bishop Realty
Courtesy to brokers

Permanent financing:
Metropolitan Life Insurance Company
Interim financing: First Hawaiian Bank
Bank of California, Seattle
Columbia University of New York

WONDA-CHAIR

NO FINER BABY SAFETY EQUIPMENT IN THE WORLD

PROVIDING— • ABSOLUTE SAFETY • QUALITY • CONVENIENCE • ECONOMY

Since being introduced WONDA-CHAIR *has been awarded*

A. PARENTS MAGAZINE COMMENDATION — B. GOOD HOUSEKEEPING SEAL
C. AMERICAN MEDICAL ASSOCIATION AUTHORIZATION

Franchised Hawaiian Dealer is

M & S DISTRIBUTORS

1614 KALAKAUA AVE. — PHONE 949-0908

NOT SOLD IN STORES

POST-GRADUATE SYMPOSIUM—ARTHRITIS

A symposium on arthritis and related disorders will be held by New York University Post-Graduate Medical School, 550 First Avenue, Manhattan, Feb. 28 through Mar. 3, 1972. The symposium is designed for physicians and researchers seeking detailed knowledge of a number of forms of arthritis, rheumatic fever, systemic lupus erythematosus and gout. For registration, information, and application, write: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y. 10016.

TWELFTH CONGRESS OF THE PAN-PACIFIC SURGICAL ASSOCIATION

February 26 to March 4, 1972, Hilton Hawaiian Village Hotel, Honolulu. Concurrent meetings will be held on: Anesthesiology, Colon & Anorectal Surgery, General Surgery, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-Cardiovascular, and Urology. For details write: Cesar B. DeJesus, M.D., Pan-Pacific Surgical Association, 236 Alexander Young Bldg., Honolulu, HI 96813.

FIFTH ASIAN-PACIFIC CONGRESS OF CARDIOLOGY

Hosted by the Singapore Cardiac Society under the auspices of the Asian-Pacific Society of Cardiology, the fifth congress will be held October 8-13, 1972 in Singapore. For registration, information, and application, write: Dr. N. C. Tan, Secretary-General, 5th Asian-Pacific Congress of Cardiology, c/o Faculty of Medicine, University of Singapore, College Road, Singapore 3, Republic of Singapore.

Dial 537-5353

for the finest printing service in the state

star-bulletin printing company

420 WARD AVENUE HONOLULU, HAWAII 96814

INSURANCE EXCLUSIVELY

Brainard & Black, Ltd.

1712 S. King Street, Honolulu 96814

Telephone: 949-0031

"Small enough to know you, Large enough to serve you"

medicine is not a cut-rate field.

Too much is at stake to cut corners by cutting service. At Amfac you will find the lowest prices and the best terms consistent with the service you deserve and the standards you demand. Large, local stock. Fast, dependable four-times-a-day delivery service. 30 days to pay.

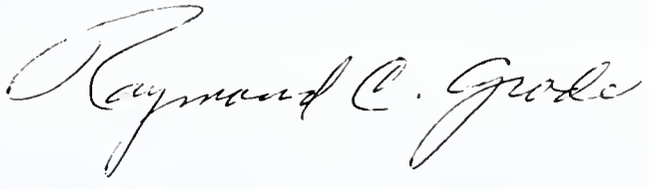
At Amfac medicine is not a cut-rate field.



MANAGER



SALES MANAGER — DRUG

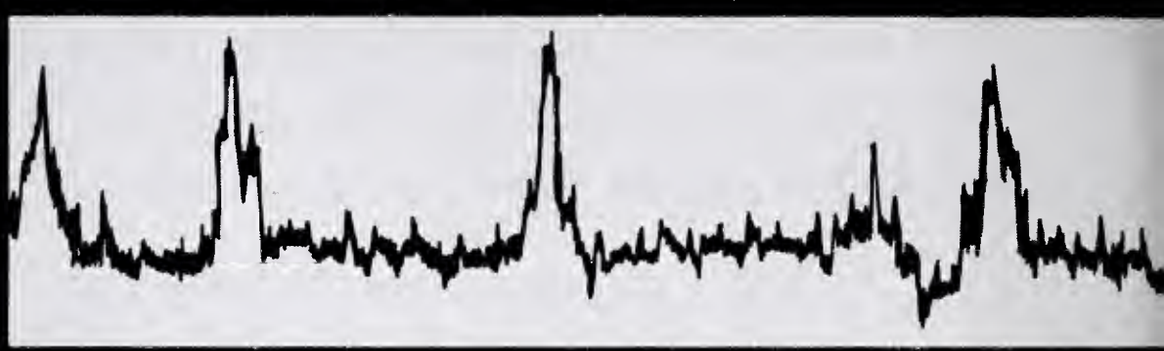


MANAGER — MEDICAL EQUIPMENT

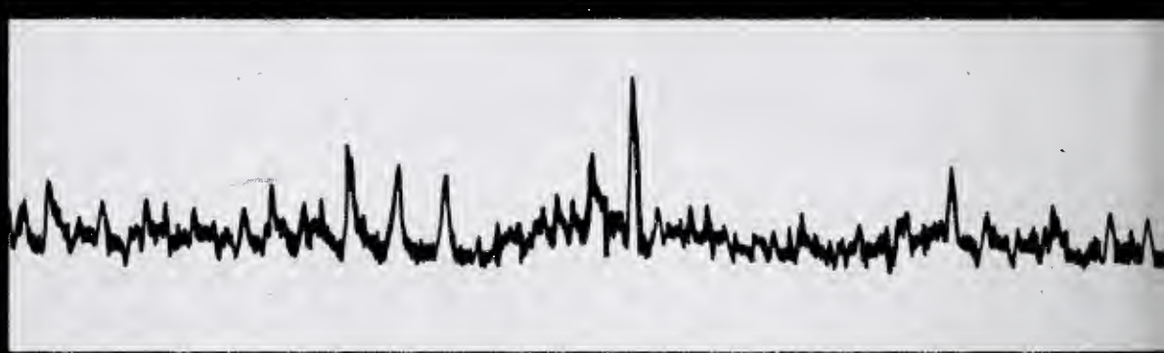
Amfac
DISTRIBUTION COMPANY
Drug Department
PHONE 533-0315

An intestinal autobiography of rage, contentment and horror*

"Feeling unfairly taxed by the government (Internal Revenue Service) and not given enough attention by A.U.O. [an experimenter to whom the subject became very attached], he became overtly critical and accusatory. He shouted, raged, and threatened to quit."*



"The motility that day was quiet. This type of recording is seen regularly when he is relaxed and contented and the laboratory seems peaceful."*



He was overwhelmed by "paralyzing horror" when told he would need a partial laryngectomy for removal of an early carcinoma; "...the activity of the ileum virtually ceased for over a five-minute period...."*



Background

*Data presented here derive from a 13-year ongoing study by Henry Harrison Sadler, M.D., and Aline Underhill Orten, Ph.D., at Wayne State University. Their findings, which demonstrate a correlation between the emotional state of a human subject and the motility of an isolated segment of his ileum, were published in the April, 1968, *American Journal of Psychiatry*, volume 124, page 1375.

The subject is a 56-year-old man with a 40-cm Thiry loop of ileum created as a result of emergency surgery. A person of modest attainment and simple tastes, the subject depends on the investigators as he might his own family. His full-time job is as a "human laboratory," and throughout the 13-year period of the study, he has taken great personal pride in his own participation.

A story charged with emotion

The graphs on the facing page are intestinal motility readings on a human subject experiencing the emotions of rage, contentment and horror (see "Background" below left). This "intestinal autobiography" dramatizes the point that certain emotions correlate with specific patterns of G.I. motility.

The visceral clutch and functional G.I. disorders

The gut response to stress has been amply demonstrated in many functional G.I. disorders. Nervous diarrhea and irritable colon syndrome, for example, are disorders associated with abnormal G.I. motility. And these disorders are commonest among patients sensitive to life-stress situations productive of conflict and excessive anxiety.

Librax® calms anxiety, calms the gut

In these areas of G.I. pathology, Librax has become a mainstay of adjunctive therapy. Reason? Effective two-way calming action. Librax, by relieving excessive anxiety, not only helps calm emotional overreaction to stress, it controls intestinal hypermotility, too. Depend on Librax—the only drug that combines the well-known antianxiety action of Librium® (chlordiazepoxide HCl) and the potent, dependable antisecretory/antispasmodic action of Quarzan® (clidinium Br).

1 or 2 capsules, 3 or 4 times daily in the treatment of nervous diarrhea and irritable colon syndrome

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

In functional G.I. disorders, adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

calms anxiety, calms the G.I. tract

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Our "Angels"

	PAGE
Amfac Distribution Company	
Drug Department	517
Arch Laboratories	
Dicarbosil	503
Ayerst Laboratories	
Premarin	458, 459
Bishop Trust Co., Ltd.	454
Brainard & Black, Ltd.	516
Buscom Hawaii	509
Burroughs Wellcome Co.	
Empirin Compound	508
California Medical Association	511
Campbell Soup Company	
Soup	483
Coca-Cola Bottling Company of Honolulu, Inc.	462
Dorsey Laboratories	
Triaminic	495
Hawaii Medical Service Association	500
Lederle Laboratories	
Achrostatin V	512
Declostatin 300	528
Lilly, Eli, & Co.	
V-Cillin K	463
Marco Polo	515
Medical Industries, Ltd.	505
Medical Placement Bureau	509
Medi-Trans, Ltd.	514
Med Sec Services	503
M & S Distributors	516
National Drug Company	
Tepanil/Quinamm	Insert (between 456 & 457)
Newton, C. R., Co., Ltd.	505
O'Leary, Lydia, of Hawaii	
Covermark	514
Optical Dispensers of Hawaii, Inc.	462
Physician's Ambulance Service, Inc.	520
Robins, A. H., Co., Inc.	
Robinul	522, 523
Phenaphen/Dimetapp	Insert (between 460 & 461)
Roche Laboratories	
Librax	518, 519
Valium	524, 525
Noludar	450, 451
Searle, G. D., & Co.	
Ovulen/Demulen	526, 527
Shirley Olds	513
Smith Kline & French Laboratories	
Dyazide	460
Star-Bulletin Printing Company	516
Stuart Pharmaceuticals	
Mylanta	456
Trent Medical Personnel Bureau	510
Upjohn Company, The	
E-Mycin	452
Wallace Pharmaceuticals	
Miltown	461
Williams Mortuary	505
Winthrop Laboratories	
Neo-Synephrine HCl	457
NTZ Nasal Spray	521

OXYGEN
H.L.R.

24-HOUR SERVICE

AIR-CONDITIONED
CADILLACS

Physician's



531-0477

AMBULANCE SERVICE, INC.

Hawaii's Finest

as easy as NTZ®

An easy solution to the problem of nasal symptoms of hay fever, colds and sinusitis

easy to prescribe: just write NTZ Nasal Spray.

easy to recommend: just say NTZ Nasal Spray.

easy to use: just one spray in each nostril, quickly followed by a second spray. Repeat q. 3 h. or q. 4 h. for temporary relief.

easy to dispense: the outer sleeve of the package is removable for easy application of prescription label.

easy to remember: as easy as NTZ.

But more than a simple vasoconstrictor:

NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine®, 0.5 per cent, the more potent solution (adult strength) in a carefully balanced formula which includes: **Neo-Synephrine** (brand of phenylephrine) HCl 0.5 per cent, decongestant **Thenfadil®** (brand of thenyldiamine) HCl 0.1 per cent, antihistamine **Zephiran®** (brand of benzalkonium, as chloride, refined)Cl 1:5000, wetting agent

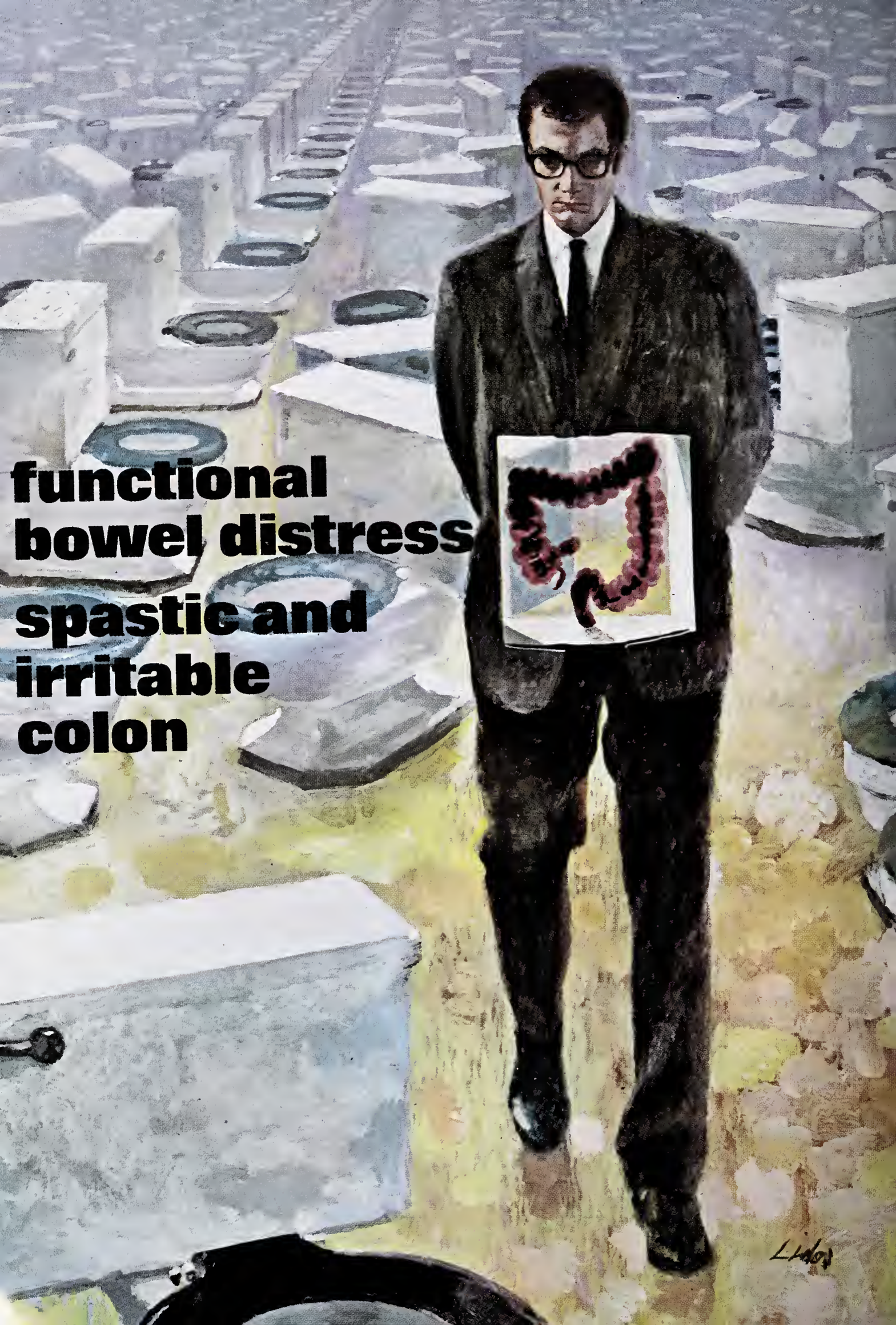
Available: NTZ Nasal Spray in squeeze bottles of 20 ml.; NTZ Solution in bottles of oz. with dropper.



prescribe NTZ® Nasal Spray

(Contains Neo-Synephrine)

Winthrop Laboratories, New York, N. Y. 10016 Winthrop


functional
bowel distress
spastic and
irritable
colon

move up to "the Robinul response"

when lower G-I symptoms demand a potent synthetic antispasmodic

In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

Robinul® 2 mg. Forte (glycopyrrolate)

■ **INDICATIONS** Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va.

A·H·ROBINS



His first sit-ups in 15 years sets up a visit to your office

When you see him, he can
ardly straighten up, let alone work
ut at the gym. One more case of
verexerting underexercised muscles.
alium (diazepam) as an adjunct
n skeletal muscle spasm can
elp break the reflex cycle of
pasm/pain/spasm. The sooner you
an relieve your patient's skeletal
nuscle spasm, the sooner he can get
ack to getting into shape on a more
raduated exercise program.

If your patient can't get to sleep,
n *h.s.* dose of Valium added to the
i.d. dosage may enable him to get a
ood night's rest.

VALIUM® (diazepam)

2-mg, 5-mg, 10-mg tablets
useful adjunct in skeletal
muscle spasm

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

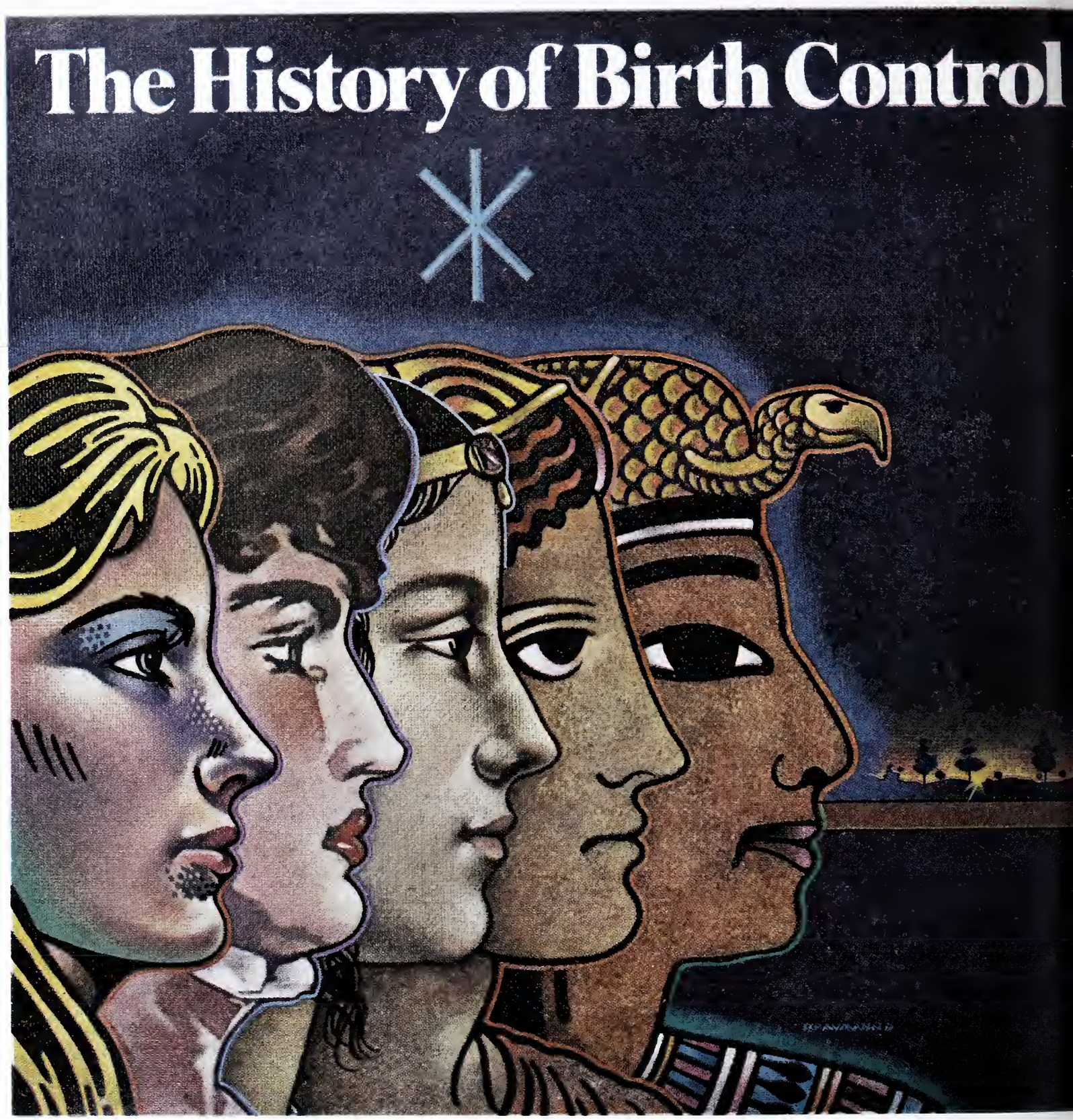
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

The History of Birth Control



After a 4,000-year search, have women finally found freedom?

Abortion and infanticide have, throughout history, been the final and desperate resort of women who were unable to control their fertility, but for almost 4,000 years they have sought ways to prevent conception.

181815

In ancient Egypt they used pessaries of crocodile dung or tried to clog the motile sperm with honey and a gumlike substance. The women of Islam used tampons of pomegranate pulp and rock salt. In Japan they burned little balls of "burning grass" on the *mons veneris* or, more practically, tried to cover the mouth of the uterus with disks of oiled bamboo tissue paper. In the 18th Century in France upper-class women rediscovered the vaginal sponge, a device mentioned in sources as old as the Talmud.

It may seem now that such advances as oral contraception and the IUD have freed women from this often fruitless search and consequent suffering, but there are millions of women in the United States and elsewhere who have less knowledge of, and less recourse to, contraceptio than Egyptian women of the Twelfth Dynasty. Nothing is more urgent to all of us than to bring them help. We cannot long support the ecologic pressures of an additional 70 million Earth inhabitants each year.

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
JUL 17 1973
RETURNED
JUL 12 1973
7 DAY
JUN 13 1975
RETURNED
JUN 9 1975

15m-7,'72(Q3551s4)4315-A33-9

270330